

Sport(s) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**William S. Hart Union High School District**  
**CERTIFICATE OF PHYSICAL EXAMINATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_ BP: \_\_\_\_\_

Please place an "X" as either Normal or Abnormal for all findings below. Please describe in detail all abnormal findings.

	Normal	Abnormal	Comments
Heart			
Pulses			
Lungs			
Neck			
Back			
Shoulder/Arm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle/Foot			
Other Pertinent Medical Findings			

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any restrictions and duration: \_\_\_\_\_  
\_\_\_\_\_

I hereby certify that \_\_\_\_\_ was examined by me on \_\_\_\_\_ 20\_\_\_\_  
and found to be physically fit to engage in athletics.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Stamp name or attach card of medical office here:

Parents: Please complete the Medical History information on the reverse side of this form prior to meeting with your physician.

# William S. Hart Union High School District

## MEDICAL HISTORY TO BE COMPLETED BY PARENT/GUARDIAN BEFORE PHYSICAL EXAM

Name of Student-Athlete \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

**Y or N** (Circle Y or N. If "Yes" explain)

1. Has the student-athlete had a medical illness or injury since his/her last check up or sport physical? Y N

Date of Incident \_\_\_\_\_ Type of Illness or Injury \_\_\_\_\_

2. Is the student-athlete currently taking any prescription or nonprescription (over-the-counter) medication

or using an inhaler? Type of Medication \_\_\_\_\_ Y N

3. Does the student-athlete have any allergies (for example, pollen, medicine, food, or stinging insects)? Y N

Type of Allergy \_\_\_\_\_

4. Has the student-athlete ever had a seizure? Y N

Date of Incident \_\_\_\_\_

5. Has the student-athlete ever become ill from exercising in the heat? Y N

Date of Last Incident \_\_\_\_\_

6. Is there any pertinent medical information coaches or physicians should know about the student-athlete? Y N

\_\_\_\_\_

7. Does the student-athlete wear glasses, contacts, or dental braces? \_\_\_\_\_ Y N

8. Has the student-athlete ever been diagnosed with a concussion? Y N

Dates of Incidents \_\_\_\_\_

Please indicate the longest amount of time that the student athlete has missed activity due to a concussion?

\_\_\_\_\_

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

-----Complete this side prior to visiting the physician.-----

March 2020,