



APPLICATION FORM

Physical Examination Form

TO BE COMPLETED BY PHYSICIAN, PHYSICIAN ASSISTANT or NURSE PRACTITIONER

NAME: _____ D.O.B.: ___/___/___ Grade: _____ Sport(s): _____

1. Does the child have a *diagnosed* medical condition? YES/NO
 IF YES (e.g., seizure, asthma, diabetes, heart problem, etc...) Please specify: _____

2. Does the child have any *allergies*? YES/NO
 If YES please list: _____

**** IF YES to EITHER of the 2 questions above, does the condition require EMERGENCY ACTION while at camp or athletic activities? Please describe necessary action (Epipen, Inhaler, Rescue meds).**

3. Is the child on regular medication? YES/NO
 IF YES – Name of Medication(s) - _____

4. Has the child been tested for *SICKLE CELL*? YES NO UNKNOWN; IF YES please circle the results: POS, NEG, POSITIVE TRAIT

HEIGHT _____ WEIGHT: _____ BP: _____ HEART RATE: _____

GENERAL MEDICAL	WNL	Abnormal
General Appearance		
Skin		
E N T		
Dental		
Lymph Nodes		
Chest		
Heart/Cardiac		
Lungs		
Abdomen		
Hernias		
Endocrine		
Other		

MUSCULOSKELETAL	WNL	Abnormal
Spine (Neck/Back)		
Shoulders		
Arms / Elbow		
Elbows		
Hands/Wrists		
Hips		
Legs		
Knees		
Ankles		
Feet		
Neurological/Sensory		
Other		

HEALTH AREA CONCERN	WNL	Abnormal
ADD / ADHD		
Behavior/Adjustment		
Psychosocial		
Development		
Hearing		
Immunodeficiency		
Lead Exposure/Elevated Lead		
Learning Disabilities/Problems		
Nutrition		
GI / GU		
Speech/Language		
Other		

Note: should the above named individual have any restrictions, a letter from the individual's physician must accompany this form explaining all medical conditions as well as indicated restrictions and level of participation.

CLEARED NOT CLEARED REASON/REMARKS: _____

By signing below, I certify that I have on this date examined this student and that based on the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it inadvisable for this student to participate in supervised physical and athletic activities.

 PHYSICIAN(MD/DO), PA, NP Printed Name PHYSICIAN(MD/DO), PA, NP Signature DATE

Address Street (REQUIRED) City State Zip

Telephone Number (REQUIRED): _____