BOWRING SCHOOL PHYSICAL

NAME: _____ GRADE: _____ DOB: _____ AGE: _____
HOME ADDRESS: _____
PARENTS NAME: _____ HOME PHONE _____
FAMILY PHYSICIAN: _____ PHONE: _____

1. Have you ever been told not to participate in any sport activity? Yes No
2. Have you ever been knocked out or lost memory from a head injury? Yes No
3. Have you ever had a fracture, dislocation, sprain or other injury? Yes No
4. Do you have any vision problems or loss of an eye? Yes No
5. Have you ever had heart or blood pressure problems? Yes No
6. Do you have any illnesses now? Yes No
7. Do you take any medicine every day? Yes No
8. Have you ever had a serious illness or loss of body part? Yes No
9. Have you ever fainted or blacked out during exercises? Yes No
10. Do you have allergies (hay fever, hives, asthma, etc.)? Yes No
11. Have you been hospitalized for an operation or any other reason? Yes No
12. Do you have any worries about your health, or other questions you would like to discuss with a physician? Yes No

Explain any questions answered with YES (use back of sheet if needed).
Date of last tetanus booster: _____
Student _____ has my permission for physical examination and my permission to participate in school sports.

_____ _____
Parent or Legal guardian Date

PHYSICIANS USE ONLY

Height _____ Weight _____ Blood Pressure _____ H.E.E.N.T. _____
Neck _____ Lungs _____ Heart _____ Hernia _____ Abdomen _____
Dental _____ Skin _____ Neurological _____
Muscular skeletal _____

_____ _____
Approved Disapproved