FATHER DUEÑAS MEMORIAL SCHOOL

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Physical Examination

To parents & legal guardians: To proide the best educational experience, school personnel must understand your son's health needs. This form requests this information from you (Part 1) which will also be helpful to the licensed health care provider when he/she completes the Physical Examination Report (Part 2). This form may also he used for helath assessments required every year for students participating in interscholastic sports.

Part 1: Medical History and Parental Consent

This part of the form must be completed by the student's parents or legal guardians prior to the student's physical examination. The information will be reviewed by the physician or licensed physician assistant during the examination. Please print using blue or black ink.

Student Name *(Last Name, First Name)* ______ Birth Date ______ Age ______ Current Grade ______ Sex ______

Father's Name *(or legal guardian)* ______ Phone Number ______ Mother's Name *(or legal guardian)* ______ Phone Number ______

Please check the appropiate box indicating if the student has any history of the listed condition. If yes, please indicate age or date of condition:

	Yes	No	When?		Yes	No	When?
Vision Problems	❑	❑		Breathing or Lung Problems	❑	❑	
Hearing Problems	❑	❑		Asthma	❑	❑	
Heart Disease or Problems	❑	❑		German Measles	❑	❑	
Chest Pains	❑	❑		Measles	❑	❑	
High Blood Presure	❑	❑		Anemia	❑	❑	
Bone or Joint Problems	❑	❑		Rheumatic Fever	❑	❑	
Bone Fractures	❑	❑		Hay Fever	❑	❑	
Skin Disease or Problems	❑	❑		Mumps	❑	❑	
Severe Headaches	❑	❑		Chicken Pox	❑	❑	
Dizziness or Unconscieusness	❑	❑		Hernia Rupture	❑	❑	
Convulsions	❑	❑		Tuberculosis	❑	❑	
Head Injuries or Concussion	❑	❑		Diabetes	❑	❑	

Does the student have any long term disabiilty? ❑Yes ❑No If yes, please specify: ______

Does the student have any alergies? ❑Yes ❑No If yes, please specify: ______

Is the student currently taking any medication? ❑Yes ❑No If yes, please specify: ______

Has the student ever been hospitalized? ❑Yes ❑No If yes, please explain: ______

Parent or Legal Guardian Consent

I hereby give my permission for the physician or licensed physician assistant to examine my son, as named above, so that he may obtain health/medical clearance to participate in the school activities, including physical education classes, National Junior ROTC and/or interscholastic athletics. Therefore, the examining health care provider, Father Dueñas Memorial School, and IIAAG will not be liable for any abnormalities not detected in this examination.

I understand that this clearance neither obligates nor guarantees my son's participation in school activities and that participation in any school activity may involve additional requirements.

Signature of Parent/Legal Guardian ______ *Print Name* ______ *Date* ______

Part 2: Physical Examination Report

To the examining physician: Please complete and sign this physical examination report.

Height (ft-in): ______ Weight(lbs.): ______ Pulse: ______ Resp.: ______ Blood Pressure: _____/_____ Vision: R______ L______

The physical examination of the student revealed the following abnormalities or concerns:

1. ______
2. ______
3. ______
4. ______

This student may: ❑**participate fully in school activities including physical education class and/or NJROTC**
❑NOT participate fully in the school activities. He has the following restrictions/adaptations: ______

This student may: ❑**participate fully in interscholastic athletics and sports teams.**
❑NOT participate fully in interscholastic athletics and sports teams. He is restricted from the innitialed sports below:

Baseball: _____ Basketball: _____ Cross Country: _____ Football: _____ Golf: _____ Paddling: _____
Rugby: _____ Soccer: _____ Track & Field: _____ Tennis: _____ Volleyball: _____ Wrestling: _____

Signatue of Licensed Examiner ______ *Print Name of Examiner* ______ *Clinic* ______ *Date* ______

Required for Wrestlers Only (must be completed by a physician):

Current Weight (lbs.): ______ Safe Weight Range for Student to Wrestle (lbs. he can safely loss or gain): ______

Physicin's Signature ______ *Print Name* ______ *Date* ______