

(To be completed by the doctor. NO OTHER FORM IS ACCEPTABLE)

This form must be completed by a physician and on file in the School Nurse's office before the student will be allowed to practice, to draw equipment or to compete in interscholastic athletics. This physical is valid from the date of the exam for one calendar year.

COMMENTS:

(PLEASE PRINT) Student Name _____

Grade _____ Age _____ Height _____ Weight _____ BP _____

Significant Past Illness or Injury _____

Eyes _____ R 20/ _____ L 20/ _____

Ears _____ Hearing _____ R _____ L _____

Respiratory _____ Cardiovascular _____

Liver _____ Spleen _____

Hernia _____ Musculoskeletal _____

Genitalia _____ Neurological _____

Skin _____

Laboratory: Urinalysis _____ Other _____

Immunization: Tetanus _____ Polio _____

"I certify that I have on this date examined this student and that, on the basis of this 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 medically inadvisable for this student to compete in supervised athletic activities, EXCEPT THOSE CROSSED OUT BELOW."

- | | | | |
|------------|--------------|----------|---------|
| Baseball | Cheering | Softball | Bowling |
| Basketball | Cross County | Soccer | Others |

Date of Examination: _____ Signed: _____ *Date:* _____
Examining Physician

Physician's Address _____ Tel. _____

MILFORD SCHOOL SYSTEM ATHLETICS:
REQUIRED MEDICAL PARTICIPATION FORM

STUDENT MEDICAL HISTORY QUESTIONNAIRE
(to be completed by the parent before doctor's exam)

PLEASE PRINT) Student Name _____ Address _____ Tel. _____

Grade _____ Date of Birth _____

Significant past injuries (fractures, concussions, lacerations, dislocations) _____

Major medical illnesses (TB, asthma, rheum. fever, diabetes, epilepsy, jaundice) _____

On medication? _____ What? _____ Reason? _____

Under doctors care? _____ Reason? _____

Wear glasses? _____ Contacts? _____ Dentures? _____ Bridges? _____

Allergies? (food, insect bites, drugs, hives, asthma, other) _____

Surgery? _____ Hospitalizations? _____

Most recent tetanus date _____

Do you know of any reason why this student should not participate in interscholastic activities? _____

Date: _____

(Parent or Guardian Signature)

(FORM TO BE COMPLETED BY PHYSICIAN ON REVERSE.)