

Date \_\_\_\_\_

**St. Charles School  
Athletic Physical**

PART 1: STUDENT INFORMATION (To be completed by parent/guardian)

**Student's name** \_\_\_\_\_ **Age** \_\_\_\_\_ **Sex** \_\_\_\_\_

**Address** \_\_\_\_\_ **Phone** \_\_\_\_\_

Date of Birth \_\_\_\_\_ Grade entering in the fall \_\_\_\_\_

Is this child subject to any of the following conditions:

	YES	NO	Explanation
Epilepsy	_____	_____	_____
Fainting	_____	_____	_____
Allergies	_____	_____	_____
Asthma	_____	_____	_____
Diabetes	_____	_____	_____
Heart Disease	_____	_____	_____
Other	_____	_____	_____
Head injury, seizures	_____	_____	_____
Knocked unconscious	_____	_____	_____
Other	_____	_____	_____

Medications

\_\_\_\_\_

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Signature of Athlete \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_

PART 2: PHYSICAL EXAMINATION (To be completed by the physician)

**Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **Blood Pressure** \_\_\_\_\_ **Pulse** \_\_\_\_\_

(Continued)

	NORMAL	OTHER
Eyes	_____	_____
Vision	_____	_____
Contact Lens	(Yes/No)	
Ears	_____	_____
Nose	_____	_____
Throat	_____	_____
Teeth	_____	_____
Bridges, Braces		
(Yes/No)	_____	
Skin	_____	_____
Neck	_____	_____
Chest	_____	_____
Lungs	_____	_____
Heart	_____	_____
Abdomen	_____	_____
Posture	_____	_____
Hernia (Yes/No)	_____	
Genitalia	_____	_____
Pubertal		
code	_____	_____
Neuralgic	_____	_____
Muscular	_____	_____
Orthopedic	_____	_____

I have examined the above student and in my opinion he/she may participate in all school organized athletics except listed: None \_\_\_\_\_

Other

\_\_\_\_\_

\_\_\_\_\_

Signature of Physician \_\_\_\_\_ Date \_\_\_\_\_