Lakewood Christian Schools

Athletic Department

PHYSICAL EXAMINATION REPORT

TO BE COMPLETED BY PARENT OR GUARDIAN:

Student's Name _____ Grade _____
Last First Middle

Birthdate _____ Age _____ Circle: Male / Female

Home Address

_____
Street Apt. No. City ZIP

Home Phone (_____)_____

Father's Work Phone (_____)_____ Mother's Work Phone (_____)_____

Father's Cell Phone (_____)_____ Mother's Cell Phone (_____)_____

TO BE COMPLETED BY STUDENT'S LICENSED PHYSICIAN AND SURGEON:

Blood Pressure: (MUST be recorded) _____S/_____D Pulse: _____

Please indicate findings for all areas below, indicate N if Normal and AB if Abnormal. Please describe in detail all abnormal findings.

Head	
Neck	
Eyes	
Ears	

Nose	
Mouth	
Teeth	
Throat	

Chest	
Heart	
Lung	
Arms	

Legs	
Abdomen	
Hernia	
Joints	

Comments on any abnormal findings:

_____

_____

1. Is there any history of acute or chronic illness? YES _____ NO _____
If YES, explain in detail _____

_____

2. Is there any history of epilepsy/seizure disorder or unconsciousness? YES _____ NO _____
If YES, explain in detail _____

_____

3. Is there any history of hospitalization? YES _____ NO _____
If YES, explain in detail (when and reason) _____
_____

4. Is student taking any medication on a regular basis? YES _____ NO _____
If YES, what medication and reason for taking it _____
_____

5. Student may participate in ALL athletic activities? YES _____ NO _____

6. Student can participate in ONLY those activities which are checked (🏂)
Flag Football _____ Volleyball _____ Basketball _____ Cheerleading_____Soccer_____

7. List any restrictions and duration _____
_____

8. Is an adapted physical education program indicated? YES _____ NO _____

If YES, state reason and duration _____

_____

9. IMMUNIZATIONS MUST BE UP TO DATE TO PARTICIPATE IN SPORT ACTIVITIES.
List dates of all immunizations given in your office during the past year.

Td: _____ MMR _____ Hepatitis B: _____ _____ _____

OPV/IPV: _____ Varicella: _____ Mantoux (PPD): _____ Results _____

LICENSED PHYSICIAN AND SURGEON'S STATEMENT:

I have examined _____
Student's name *Date*

and find that he/she may participate in the physical education programs I have indicated.

_____ Date _____
Signature of licensed physician and surgeon (NP must have physician's co-signature)

_____ Phone (_____)_____
Printed name of licensed physician and surgeon

_____
Address *City* *ZIP*

Please return this form to the school office.

SCHOOL ATHLETIC DIRECTOR VERIFICATION: (School Use Only)_____ *Signature of Athletic Director/Date*