



MEDICAL HISTORY AND PHYSICAL

Parent should complete this side of form PRIOR to appointment with physician.

STUDENT NAME _____

DATE OF BIRTH _____ GRADE _____ for school year 2010 -2011

PARENT/GUARDIAN NAME _____

ADDRESS _____ PHON E _____

HEALTH HISTORY:

Has this student had any:

YES NO

1. _____ chronic or recurrent illnesses?
2. _____ hospitalizations?
3. _____ surgery?
4. _____ missing organs (eye/kidney/testicle)?
5. _____ heart condition
6. _____ seizures/epilepsy
7. _____ fainting spells
8. _____ concussion/unconsciousness

Does this student:

YES NO

9. _____ wear eye glasses or contact lenses?
10. _____ wear dental bridge, braces, plates?
11. _____ take any medications?
12. _____ wear a prosthesis?
13. _____ have any allergies?
14. _____ have any physical limitation?
15. _____ have difficulty hearing?

EXPLAIN ANY "YES" ANSWERS _____

DATES OF ANY IMMUNIZATIONS DURING THE PAST YEAR _____

DESCRIBE ANY OTHER SIGNIFICANT PHYSICAL, BEHAVIORAL OR EMOTIONAL CONCERNS: _____

DATE: _____ PARENT'S SIGNATURE _____



PHYSICAL EXAMINATION FORM

To be completed by physician.

NAME _____ DATE OF BIRTH _____

HEIGHT _____ WEIGHT _____ BLOOD PRESSURE _____ / _____ PULSE _____
 VISION R 20/ _____ L 20/ _____ Corrected: Y N

Immunization Dates: TDAP _____ TD _____ Polio _____ MMR _____ Varicella _____

EXAMINATION	NORMAL	ABNORMAL	EXPLANATION
Skin			
Eyes			
E-N-T			
Teeth			
Cardiovascular			
Respiratory			
Abdomen			
Genitalia			
Extremities			
Neurological			
Orthopedic/Spine			
Allergies			
Endocrine			
Laboratory: Urinalysis			
Blood Count			

Recommendations to school health services or other personnel:

COMPETITIVE SPORTS CLEARANCE
 (Complete if applicable)

I consider _____ to be physically fit at the present time and up-to-date on all necessary immunizations. I consider him/her to be capable of participating in all competitive athletics for the coming school year.

CROSS OUT ANY EXCEPTIONS HERE: baseball, basketball, cross country, football, swimming, tennis, track and field, wrestling, volleyball.

DATE _____ PHYSICIAN'S SIGNATURE _____

PLEASE RETURN THIS FORM TO: *University Schools, 6525 W 18 St, Greeley CO 80634; Fax 970-506-7070*