GWENDOLYN BROOKS MIDDLE SCHOOL
INTERSCHOLASTIC SPORTS PHYSICAL EXAMINATION

Name _____ ☐ Male ☐ Female Birth Date_____
Last First Mo. Day Yr.

Address _____ Home Phone No. _____

EMERGENCY CONTACT:

Father _____ Bus. Address _____

Phone # _____

Mother _____ Bus. Address _____

Phone # _____

Other _____ Relationship _____

Phone # _____

Family Doctor _____ Phone # _____

MEDICAL HISTORY	**YES**	**NO**	**IF YES, PLEASE EXPLAIN**
1. Current Medication	___	___	_____
2. Allergies: Medicine, food, bee stings, etc.	___	___	_____
3. Appliance: Glasses, e.g. contact lenses, etc.	___	_____	
4. Dentistry: Braces, bridge, chipped teeth, etc.	___	___	_____
5. Current on-going medical problem	___	___	_____
6. Previous serious illnesses	___	___	_____
7. Surgical operations, accidents non-sports Or related injuries	___	___	_____
8. Sports related injuries	___	___	_____
9. Hospitalization not explained above	___	___	_____
10. Deformities: Spine, heart, kidney, eye, etc.	___	___	_____
11. Family illnesses: Diabetes, bleeding disorders, heart attack before 50, etc.	___	___	_____
12. Fainting or dizziness while exercising	___	___	_____

OVER

13. Ever lose consciousness or have a head injury ___ ___ _____

14. Asthma ___ ___ Medication_____

15. Last Tetanus shot _____ Last eye examination _____ Last dental examination _____

I certify the above is correct to the best of my knowledge. BOTH SIGNATURES ARE REQUIRED BELOW.

Student Signature _____

Parent/Guardian Signature _____

TO BE COMPLETED BY PHYSICAN

Student's Name _____ Date _____
Please Print

EVALUATION	NORMAL	ABNORMAL	COMMENT/FOLLOW-UP
Skin			
Eyes			
Ears			
Nose			
Throat			
Throat/Dental			
Cardiovascular B/P____			
Respiratory			
Gastrointestinal			
Genitourinary			
Neurological			
Muscular Skeletal			
Scoliosis Screening			
Nutritional Status			
Other			

Height _____ Weight _____

Pulse (normal) _____ Pulse (post exercise) _____ Heart Rate _____

Do you recommend a full activity program: Yes☐ No☐ If no, please comment _____

_____

Physician's Signature _____