Student First & Last Name _____ DOB / /

HISTORY AND PERMISSION FORMS MUST BE COMPLETED PRIOR TO PHYSICAL EXAM

STUDENT'S HEIGHT_____WEIGHT_____BP_____PULSE _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Muscular skeletal			

***Station-based examination only.**

OPTIONAL TESTS
URINALYSIS
ALBUMIN _____
SUGAR _____
MICRO (IF ABOVE TEST ABNORMAL)

BLOOD COUNT
(FOR FEMALES)
HGB. _____
OR
HCT. _____

SHOULD THERE BE ANY LIMITATIONS PLACED ON ATHLETIC PARTICIPATION? YES_____NO _____
RECOMMENDATIONS:

_____

_____

_____

_____

_____

I certify that I have on this date examined this student and that, on the basis of the examination requested by the CYO 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. (NOTE: EXCEPTIONS IN RECOMMENDATIONS AREA).

PHYSICIAN'S SIGNATURE:_____**DATE:**_____

PHYSICIAN'S TELEPHONE NO.:_____

PHYSICIAN'S NAME, ADDRESS & PHONE (STAMP OR PRINT)