



TO BE COMPLETED BY PHYSICIAN:

Student's name: _____ DOB _____
Temp. _____ BP _____ P _____ R _____
Allergies: _____

History, please check all that applies:

Diabetes _____ Osgood_Schlatter Syndrome _____
Asthma _____ Peak Flow _____ Rx _____
Epilepsy _____
Fainting _____
Has she ever been stung by a bee? _____ Reaction? _____

PHYSICAL EXAMINATION:

Ears _____ Back _____
Eyes _____ Lungs _____
Nose _____ Heart _____
Throat _____ Abdomen _____
Neck _____ Extremities _____
Dysmnenorhea _____
Other _____
Current medications: _____

MUST CHECK ALL THAT APPLY

_____ Student may fully participate in Physical Education classes
and Athletic Activities (Sports and Cheerleading)
_____ Restricted Participation-describe _____
_____ No Participation

Physician Signature _____ Date: _____
