FOREST RIDGE
THE SACRED HEART SCHOOL OF SEATTLE

PHYSICAL EXAM FORM

All students must submit completed physical exam form as follows:

Grades 5-8 Every student, every two years.
Grades 9-12 Every student participating in Athletics. Exam date within 2 years of first practice.

Student Name_____ Grade (2019-20) _____ Birthdate_____

Medical history to be **completed by patient**: Have you had any of the following? Circle yes (Y) or no (N).

1. Head injury or concussion	N	Y	12. Hernia (rupture)	N	Y
2. Bone/joint disorder (fractures, broken bones, dislocations, trick joints, back pain, arthritis)	N	Y	13. Mental illness or nervous breakdown?	N	Y
3. Eye or ear problems (disease/surgery)	N	Y	14. A "stinger" or "burner" or pinched nerve?	N	Y
4. Dizzy spells. (Fainting or convulsions)	N	Y	15 Surgery	N	Y
5. Tuberculosis, asthma or bronchitis	N	Y	16. Taking medication	N	Y
6. Heart trouble	N	Y	17. Allergies or skin problems	N	Y
7. High or low blood pressure	N	Y	18. Heat or muscle cramps	N	Y
8. Anemia, Leukemia or bleeding disorder	N	Y	19. Female: Menstrual problems	N	Y
9. Diabetes, hepatitis or jaundice	N	Y	20. Other illness or injuries	N	Y
10. Ulcers, colitis or other stomach trouble	N	Y	21. Do you use special equipment (pads, braces, etc.)	N	Y
11. Kidney or bladder problems	N	Y	22. Have you had a medical problem or injury since your last exam?	N	Y

Use the back of this form to explain any items for which you circled 'yes' above:

Completed by Physician: **Date of Exam**_____

Height_____Weight_____Bp_____/_____Pulse_____

Vision: R 20/_____L 20/_____ Corrected: Yes No Tetanus booster within last 5 years: Yes No

Cardiopulmonary	Normal	Abnormal	**Neck**	Normal	Abnormal
Pulse	Normal	Abnormal	**Shoulder**	Normal	Abnormal
Heart	Normal	Abnormal	**Elbow**	Normal	Abnormal
Lungs	Normal	Abnormal	**Wrist/Hand**	Normal	Abnormal
Skin	Normal	Abnormal	**Back**	Normal	Abnormal
Abdominal	Normal	Abnormal	**Knee**	Normal	Abnormal
Genitalia	Normal	Abnormal	**Ankle/foot**	Normal	Abnormal
Musculoskeletal	Normal	Abnormal	**Other**		

Clearance: A. ___Cleared B. ___ Cleared after completing evaluation/rehabilitation for_____
C. ___Cleared but not for contact sports D. ___ Not cleared

Name of Physican_____Date_____

Address_____Phone_____

SIGNATURE OF PHYSICIAN_____