

TURLOCK JUNIOR HIGH SCHOOL
ATHLETIC PHYSICAL

Name: _____ Family M.D. _____

Address: _____ City: _____ Age: _____ Birthday: _____

Sports to be played: 1. _____ 2. _____ 3. _____

(Fall-Volleyball Winter-Basketball & Wrestling Spring-Softball & Track)

<u>History:</u>	<u>Yes</u>	<u>No</u>
1. Head or back injury	___	___
2. Knee or leg injury	___	___
3. Fainting spells	___	___
4. Unconsciousness	___	___
5. Seizures	___	___
6. Braces on teeth	___	___
7. Cavities	___	___
8. False teeth . . . Caps	___	___
9. High blood pressure	___	___
10. Heart problems	___	___
11. Lung problems	___	___
12. Liver problems	___	___

<u>History:</u>	<u>Yes</u>	<u>No</u>
13. Bleeding ulcer	___	___
14. Kidney problems	___	___
15. Glasses/Contacts	___	___
16. Diabetes	___	___
17. Asthma	___	___
18. _____	___	___

Explain any "Yes" above:

Parent consent: _____

TO BE COMPLETED BY DOCTOR:

<u>Examination:</u>	<u>Abn</u>	<u>OK</u>
1. Pupils	___	___
2. Teeth	___	___
3. Heart	___	___
4. Lungs	___	___
5. Back	___	___
6. Abdomen	___	___
7. Hernia	___	___

8. Reflexes ___ ___

<u>Tests:</u>	
1. Blood Pressure:	
BP _____ mm Hg	
2. Weight: _____	
3. Height: _____	
4. Pulse: _____	

Problems:

_____ None . . . is physically fit to engage in sports.

_____ May play sports, but restricted as follows:

_____ Needs further examination by family M.D. for:

_____ Restricted for all sports at this time because:

DATE: _____

EXAMINATION BY: _____

