



Health Assessment and Medical Examination

Required for all rising 6th & 9th grade students, all students participating in athletics, all new students, and all resident students

Student Name _____ Grade _____ Date of Birth _____

Health Assessment – To Be Completed by Student and Parents

Yes	No	(Check one – give details for all YES answers and include date of occurrence)
_____	_____	Did your grandparents, parents, brothers, sisters under the age of 50 have heart problems or high blood pressure?
Have you ever had OR presently have:		
_____	_____	Heart murmur, high blood pressure, extra heartbeats, or heart abnormality? _____
_____	_____	Current medications? _____
_____	_____	Concussion or problem passing out? _____
_____	_____	Allergies? Name: _____
_____	_____	Significant illness, condition, or injury? _____
_____	_____	Hospitalization or surgery? Why? _____
_____	_____	A dental appliance? _____
_____	_____	Contacts or eyeglasses? _____
_____	_____	Need to stop while running around a ¼ mile track twice? _____
_____	_____	An illness or injury that caused you to miss a game? _____
_____	_____	Congenital absence or loss of function of one organ (eye, ear, kidney, etc.)? _____
_____	_____	Headaches (frequent)? _____
_____	_____	Asthma? Current treatment: _____
_____	_____	Convulsions (seizures)? How many? _____
_____	_____	Neck or spine injury? _____
_____	_____	Broken bones? _____
_____	_____	Sprains or dislocations? _____
_____	_____	Date of last tetanus shot? _____
_____	_____	Tested positive for Tuberculosis (TB)? Date _____ Treatment _____
_____	_____	FEMALES: Have you had a period in the last six months? How many? _____
_____	_____	FEMALES: Do menstrual cramps keep you from your regular activity? _____

I certify that the above medical history is correct to the best of my knowledge.

Parent Signature _____

PLEASE HAVE YOUR PHYSICIAN COMPLETE AND SIGN PAGE 2

Student Name _____ Grade _____ Date of Birth _____

Medical Examination – To Be Completed by Physician

VITAL SIGNS (REQUIRED)			PHYSICAL	MUSCULOSKELETAL	
Height			Appearance	C Spine	
Weight			Pupils	T Spine	
Blood Pressure			EENT	LS Spine	
Heart Rate			Dental	Shoulders	
Respiratory Rate			Heart	Elbows	
VISION	R20/	L20/	Lungs	Wrists	
CORRECTED	R20/	L20/	Abdomen	Hands	
			GU	Hips	
			Skin	Knees	
			Lymph Nodes	Ankles	Feet

NOTES: _____

Cross out any sport in which this student is not able to compete						
Baseball	Cheerleading	Football	Soccer	Swimming	Track & Field	Weightlifting
Basketball	Cross Country	Golf	Softball	Tennis	Volleyball	Wrestling

I certify that I have, on this date, examined this student and find him/her **physically able to compete** in the Ben Lippen P.E./sports program.

Physician's signature _____ Phone _____ Date _____

Print Physician's Name _____