

# DERIDDER JUNIOR HIGH

## ATHLETIC PHYSICAL

ATHLETE'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

AGE: \_\_\_\_\_

GRADE

6 7 8

M

F

DOES STUDENT WEAR GLASSES: \_\_\_\_\_

YES

NO

CONTACTS: \_\_\_\_\_

YES

NO

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ BLOOD PRESSURE: \_\_\_\_\_

RESPIRATORY: \_\_\_\_\_ CARDIOVASCULAR: \_\_\_\_\_

LIVER: \_\_\_\_\_ SPLEEN: \_\_\_\_\_ HERNIA: \_\_\_\_\_

MUSCULOSKELETAL: NECK: \_\_\_\_\_ SHOULDERS: \_\_\_\_\_ ANKLES: \_\_\_\_\_

KNEES: \_\_\_\_\_ SKIN: \_\_\_\_\_

NEUROLOGICAL: \_\_\_\_\_ GENITALIA: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

IMMUNIZATIONS: POLIO: \_\_\_\_\_ TETANUS: \_\_\_\_\_ OTHER: \_\_\_\_\_

SIGNIFICANT PAST INJURY OR ILLNESS: \_\_\_\_\_

HAS THIS CAUSED THE STUDENT TO HAVE SURGERY OR TREATMENT? YES NO

IF "YES", PLEASE EXPLAIN: \_\_\_\_\_

I certify that I have, on this date, examined this student and find him/her to be physically able to compete in the supervised sports indicated below:

FOOTBALL

BASKETBALL

TRACK

SOFTBALL

CHEERLEADING

DANCELINE

WEIGHTLIFTING

Signed: \_\_\_\_\_ Date of Examination: \_\_\_\_\_

Examining Practitioner licensed to practice medicine

Printed name/stamp: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_