PROVIDENCE DAY SCHOOL

PHYSICAL EXAMINATION FORM

Required yearly for ALL PDS athletes

Student Name:_____ Birthdate:_____ Grade:_____

Sex:_____ WT:_____ HT:_____ BP:_____

MEDICAL HISTORY (to be completed by parent/guardian)

Is there a known history of:

1.	Birth deformities (one eye, one kidney, etc.)?	Yes [ ]	No [ ]
2.	Known past illness of more than one week's duration?	Yes [ ]	No [ ]
3.	Medical conditions currently under treatment?	Yes [ ]	No [ ]
4.	Fractures or other disabling injuries?	Yes [ ]	No [ ]
5.	Any permanent deformity or disability?	Yes [ ]	No [ ]
6.	Allergy (drugs, food, environmental, etc.)?	Yes [ ]	No [ ]
7.	Asthma (exercise induced or otherwise)?	Yes [ ]	No [ ]
8.	Seizures or other neurological disorders?	Yes [ ]	No [ ]
9.	Heart murmur, high blood pressure, or heart abnormality?	Yes [ ]	No [ ]
10.	Sickle Cell trait?	Yes [ ]	No [ ]
11.	Concussions/loss of consciousness?	Yes [ ]	No [ ]

If yes to any of the above, explain:_____

_____

PHYSICAL EXAM (to be completed by MD, PA, FNP, PNP):

Eyes (Glasses/Contacts?):_____ Extremities:_____
ENT:_____ Posture (Spine):_____
Teeth:_____ Renal:_____
Heart:_____ Abdomen:_____
Lungs:_____ Genitalia: _____
Allergy (please specify):_____
Skin:_____ **Date of last Tetanus Booster**: _____
General appraisal:_____
_____

Physical Activity: (please provide explanation if necessary)

_____ Full participation including competitive sports
_____ Restricted participation (note restriction)
_____ No participation

_____ _____
Signature of Physician Date of Exam

Physical is VALID for one year from the date of your doctor visit