(To be completed by the doctor. NO OTHER FORM IS ACCEPTABLE)

This form must be completed by a physician and on file in the School Nurse's office before the student will be allowed to practice, to draw equipment or to compete in interscholastic athletics. This physical is valid from the date of the exam for one calendar year.

COMMENTS:

_____
(PLEASE PRINT) Student Name

Grade ___ Age ____ Height_____ Weight _____BP _____

Significant past Illness or Injury_____

_____

Eyes_____R 20/_____ L 20/_____

Ears_____Hearing_____ R_____L_____

Respiratory_____Cardiovascular_____

Liver_____ Spleen_____

Hernia_____ Musculeoskeletal_____

Genitalia_____Neurological_____

Skin_____

Laboratory: Urinalysis_____Other_____

Immunization: Tetanus_____ Polio_____

I certify that I have on this date examined this student and that, on the basis of this examination requested by the school authorities and the student's medical history as furnished to me. I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities, EXCEPT THOSE CROSSED OUT BELOW.

Baseball	Cheering	Softball	Bowling
Basketball	Cross County	Soccer	Others

Date of Examination_____Signed_____
Examining Physician

Physician's Address_____Tele._____

GREENBUSH SCHOOL SYSTEM ATHLETICS: REQUIRED MEDICAL PARTICIPATION FORM

STUDENT MEDICAL HISTORY QUESTIONNAIRE
(To be completed by the parent before doctor's exam)

_____

(Please Print) Student Name Address Tele.

Grade_____ Date of Birth_____

1. Significant past injuries(fractures, concussions, laceration, dislocations)

_____

2. Major medical Illnesses (TB, asthma, rheum.fever, diabetes, epilepsy, jaundice)

_____

3. Medication_____What?_____Reason?_____

4. Under doctors care?_____Reason?_____

5. Wear glasses?_____Contacts?_____Dentures?_____Bridges?_____

6. Allergies? (food,insect bites, drugs, hives, asthma, other)_____

7. Surgery?_____Hospitalizations?_____

8. Most recent tetanus date_____

9. Do you know of any reason why this student should not participate in interscholastic activities?_____

Date:_____ _____
(Parent or Guardian Signature)

(FORM TO BE COMPLETED BY PHYSICIAN ON REVERSE.)