VAIL SCHOOL DISTRICT #20

Sports Physical Form

O=normal x=abnormal

Student Name ______________________________ Grade: __________

Address: ______________________________ DOB: __________

Matric # ______________ Date of Exam ______________

Weight __________
Height __________
Vision __________
Eyes __________
Nose __________
Throat __________
Tonsils __________
Ears __________

Glands __________
Heart __________
Lungs __________
Abdomen __________
Skin __________
Curvature __________
Feet __________
Posture __________

Orthopedic __________
Scoliosis ___Neg___Pos___
Lungs __________
Nervous System __________
Nutrition __________
Hernia __________
Urinalysis __________
Sugar _____Albumin _______

Blood Pressure (if older student): ______________ HCT: ______________
Physical Education: Regular________ Restricted (indicate) ______________
If older student: O.K. for athletics? Yes ______ No ______

Doctor's signature: ______________________________

TO PARENTS OR PHYSICIAN- PLEASE FILL IN INFORMATION IF THIS INFORMATION HAS NOT BEEN PROVIDED TO SCHOOL AS OF THIS DATE

IMMUNIZATIONS	DATES	DISEASE HISTORY	DATES
SMALL POX		CHICKENPOX/ VARICELLA	
DIPTHERIA-PERTUSIS-TETANUS		MEASELS REGULAR/3 DAY	
DIPTHERIA-TETANUS		MUMPS	
POLIO (SABIN) TYPE I		WHOPPING COUGH	
TYPE II		ALLERGY/ASTHMA	
TYPE III		RHEUMATIC FEVER	
TRI-VALEN		VALLEY FEVER	
BOOSTER		INFECTIOUS HEPATITIS	
TUBERCULIN POS__ NEG__		OTITIS (EAR INFECTION)	
MEASLES IMM. (10 DAY)		DIABETES	
RUBELLA IMM.(3 DAY)		ANEMIA	
MUMPS VACCINE		CONVULSIVE DISORDER	

Parent/Guardian signature: ______________________ Date: ______________

Doctor's recommentation & comments: ______________________________

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