2026/2027 HIGH SCHOOL PHYSICAL SCREENING

**Date of Physical exam must be June 1, 2026 or later

** ***NO EXCEPTIONS***

HISTORY *(Must be completed and signed by parent prior to examination):*

SPORT:_____ SCHOOL: **NORTH HIGH** DATE:_____

_____

PRINT Last Name First Name M.I. Grade Age Date of Birth

_____

Address City Zip Code

HEALTH HISTORY *(To be completed by student or parent):*

Check and give as much information as possible **Y = yes, N = no**

____Heart Trouble ____High Blood Pressure ____Asthma ____Diabetes

____Kidney Problems ____Head Trauma ____Seizures ____Other (List below)

_____

History of any previous injuries, fractures, serious illnesses or operations (Give year of problem)

_____

Current medications Allergies Last Tetanus Immunization

*SIGNATURE OF PARENT OR GUARDIAN:*_____

PHYSICAL EXAMINATION **(To be completed by physician):**

Height:_____Weight:_____Temp:_____Blood Pressure:_____Pulse:_____Respirations:_____

Visual Acuity: O.D.____/____ O.S.____/_____ ( ) Corrected ( ) Uncorrected L.M.P._____

( )Chest Pain ( )Extreme S.O.B. ( )Dizziness ( )Fatigue ( )Palpitations ( )Sudden Death of Family Member

	NORMAL		
		10. MUSCULOSKELETAL, ROM, STRENGTH	
		NECK	
1. EYES		SPINE	
2. EARS, NOSE, THROAT		SHOULDERS	
3. MOUTH AND TEETH		ARMS/HANDS	
4. NECK		HIPS	
5. CARDIOVASCULAR		THIGHS	
6. CHEST AND LUNGS		KNEES	
7. ABDOMEN		ANKLES	
8. SKIN		FEET	
9. GENITALIA-HERNIA(MALE)		11. NEUROMUSCULAR	

ABNORMAL FINDING:_____

_____

RECOMMEND: ( ) Full Activity, No Restrictions

( ) Activity with Restrictions: ( ) No contact sports ( )Other:_____

( ) No Participation

EXAMINING PHYSICIAN: Name_____ License#:_____ Date:_____

Address:_____ **Doctor's Stamp here:**

Phone #:_____ **Date of Exam**: _____