



ATHLETIC MEDICAL AUTHORIZATION

Please Print (Last Name) (First Name) (Initial)

Grade _____

Birth date _____

Eyes R _____ L _____ Glasses _____ Hearing: R _____ L _____

Height _____ Weight _____

Ear, Nose, Throat _____

Lungs _____

Diabetes _____

Pulse _____

Blood Pressure and Heart _____ Heart Murmur _____

Deformities or Present Illness _____

Prosthesis _____

Hernia Evidence _____ Concussion _____ Epilepsy _____

Other _____

Would athletic competition be injurious? _____

I hereby certify that, on this date, I examined the above student and recommend him/her as being physically able to participate in all supervised athletics and physical education activities, except as noted:

Date Signature of Examining Physician

Health History

_____ allergy to bee sting

_____ heart murmur

_____ anemia

_____ hepatitis

_____ arthritis

_____ hernia

_____ asthma

_____ hives

_____ concussion

_____ kidney trouble

_____ diabetes

_____ migraine headaches

_____ eczema

_____ pneumonia

_____ emotional problems

_____ rheumatic fever

_____ epilepsy

_____ other

_____ fainting

Operations: (Include this year)

Fractures: (Include this year)

To which drugs is the student allergic?

If student is now under medical treatment, list reason and attending doctor:
