

STUDENT PARTICIPATION AND PHYSICAL EXAM FORM FOR WHEELING PAROCHIAL LEAGUE

Please Print

Student's Name _____ Birthdate _____
Last First M.I.
 Sex _____ Place of Birth _____ Grade as of 8/12: _____
 City _____ School _____
 Student's Address _____
Street City Zip
 Parent(s) Name _____
 Address (if different than student's) _____
Street City Zip

Family Physician's Name; Address; and Phone Number

Athlete's History	YES	NO
Has this athlete ever had hospitalization, surgery, injury, or serious medical illness?	_____	_____
Is this athlete now under the care of a physician or taking any medications?	_____	_____
Has any physician ever recommended or do you feel that there should be limits placed on participation in competitive sports?	_____	_____
Does this athlete have any known allergies to medications?	_____	_____
Does this athlete wear glasses or contact lenses?	_____	_____
If YES give date of last eye exam _____	_____	_____
Has the athlete ever blacked out or lost consciousness during physical activity?	_____	_____
If YES, please specify:		

We consent to the participation of the above named student in the interscholastic program of his/her school, including practice sessions and travel to and from Athletic contest. We also agree to emergency medical treatment as deemed necessary by the physicians designated by school authorities.

Student _____ Parent _____ Date _____

History and consent should be completed prior to the physical examination.

HEALTH EXAMINATION FORM

Student's Name _____
 Height _____ Weight _____ Pulse _____

Optional Tests
 Urinalysis
 Albumin
 Sugar
 Micro9 (if sugar abnormal)

Abnormal physical findings (including infectious or contagious diseases) _____
 BLOOD COUNT
 HGL or
 HCT

Should there be any limitations placed on athletic participation? YES _____ NO _____
 Recommendations: _____

I certify that I have on this date examined this student and that, on the basis of the 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. (Note exceptions above)

physician's signature _____ physician's telephone number _____ date _____