Westford Public Schools - Athletics Physical Form

(*For use only when the physical is being done thru the school clinic)*

To be completed by parent or guardian (please print)

Student's Last Name	First Name	School	Grade
Parent or Guardian Last Name	First Name	Student Date of Birth	
Address		Home Phone	Work Phone

Sport_____ ☐ Male ☐ Female

Check any health problem:

	Yes	No		Yes	No
Allergies	☐	☐			
Asthma	☐	☐	Uses inhaler	☐	☐
Convulsions/seizures	☐	☐	Concussion (head injury)	☐	☐
Fainting spells	☐	☐	Operations	☐	☐
Fracture	☐	☐	Knee injury	☐	☐
Back injury	☐	☐	Neck injury	☐	☐
Shoulder injury	☐	☐	Hip injury	☐	☐
Foot/ankle injury	☐	☐	Diabetes	☐	☐
Heart problem	☐	☐	Cancer	☐	☐
Single organ i.e. kidney	☐	☐	Wears dental appliance	☐	☐
Wears glasses/contact lenses	☐	☐			

Explain any checked yes and provide date:_____

_____

List all medications taken within the last 12 months:_____

Have any of the following ever been documented in close relatives of your son/daughter?

Sudden death ☐ Yes ☐No Allergies ☐ Yes ☐ No Convulsions ☐ Yes ☐ No

☐ I give my son/daughter permission to have a sports physical **and** I have provided a check for $ _____

_____ _____

Signature of parent or guardian ***Date***

To be completed by Health Care Provider only

Ht:_____ **Wt:**_____ **BP:**_____

Physical Exam_____

_____

Recommended: ☐ **Yes** ☐ **No** ☐ **Yes with exceptions:**

Exceptions:_____

_____

Health Care Provider's Signature ***Date of Examination:***