

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	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Uses inhaler	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Concussion (head injury)	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Operations	<input type="checkbox"/>	<input type="checkbox"/>
Fracture	<input type="checkbox"/>	<input type="checkbox"/>	Knee injury	<input type="checkbox"/>	<input type="checkbox"/>
Back injury	<input type="checkbox"/>	<input type="checkbox"/>	Neck injury	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder injury	<input type="checkbox"/>	<input type="checkbox"/>	Hip injury	<input type="checkbox"/>	<input type="checkbox"/>
Foot/ankle injury	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart problem	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Single organ i.e. kidney	<input type="checkbox"/>	<input type="checkbox"/>	Wears dental appliance	<input type="checkbox"/>	<input type="checkbox"/>
Wears glasses/contact lenses	<input type="checkbox"/>	<input type="checkbox"/>			

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: