LAWRENCE SCHOOL DISTRICT

Sports Physical/Parental Consent

Student _____ Age _____ Sex _____
Grade _____ Birthdate _____ All Sports _____ School Building _____
Parents Name _____ Address_____

PART A – To be completed by the parent/guardian:

History since last physical:		**YES**	**NO**
1)	Has your child experienced any type of head injury or concussion requiring medical attention?		
2)	Has your child received any injury requiring medical attention?		
3)	Has your child had any surgical operations, joint injuries, or fractured bones?		
4)	Has your child been treated in a hospital or emergency room?		
5)	Has your child been diagnosed with any condition requiring medical attention?		
6)	Has your child experienced swelling or pain requiring medical attention?		
7)	Has your child missed any practices and/or games due to illness or injury?		
8)	Has your child been absent from school for five (5) or more consecutive days (or an equivalent period during the summer) due to an accident or illness requiring medical care?		
9)	Has injury or illness prevented your child from exercise or other athletic activities?		
10)	Is your child currently using an inhaler, taking any over the counter/prescription medications or herbal preparations?		
11)	Will your child carry any medication or pills or inhaler in school or at sports activities?		
12)	Has your child experienced any feelings of faintness, dizziness or fatigue after exercise or exertion?		
13)	Has there been any change in vision, such as wearing glasses or contact lenses?		
14)	Has your child developed any allergies? Asthma?		
15)	Has your child had any recent significant weight gain or weight loss?		
16)	**Females Only:** Has there been any recent changes in your menstrual cycle? _____		

If you answered "YES" to any of the above questions, please describe below:

_____
_____
_____

PARENTAL PERMISSION

I, the undersigned, clearly understand these questions are asked in order to decide if my child can safely participate in all sports except _____. The answers are correct as of this date and he/she has my permission to participate.

Parent Signature _____ Date _____
Student Signature _____ Date _____
Work phone _____ Home Phone _____ Cell _____

**** The Athletic Department shall provide, for publication, news releases, video's and pictures to local newspapers, MSG/Varsity and the District newsletter regarding team and student-athlete performance. Parents/Guardians who do not want this information released must express their request, in writing, to the Athletic Director.**

Lawrence School District Sports Physical Examination Form

Name of Student:		Scbool:	Grade.	DOB
Height	Weight: _ Tanner stage. __Pulse: _____BP / (/) Urinalysis			
Vision 20/___ L 20 _ Corrected: Y N		Pupils: Equal____ Unequal		
Right Ear __		Left Ear_____		
Immunizations: Last DT		Last Manitou	Results	
HB series: #1	#2	#3		

	Normal	Abnormal with comment	Initials	Exam
MEDICAL		Physician's initials (each finding, abnormal or normal)		Notes: Please list medications allergies, past medical history, past surgical history (if not listed on health history)
Appearance				
Eyes/Ears/Nose/Throat				
Thyroid				
Lymph Nodes				
Heart				
Lungs				
Pulse				
Abdomen				
Hernia				
Genitalia (males only)				
Skin				
MUSCULOSKELETAL				Details of abnormal findings
Neck				
Back/Scoliosis				
Shoulder/Arm				
Elbow/Forearm				
Wrist/Hand				
Knee				
Leg/Ankle				
Foot				

MEDICAL CLEARANCE: Check appropriate areas of participation in a competitive sport. As unmarked box indicates disqualification for that group of activities. Check all if appropriate.

Contact/Collision □ Field Hockey, Football Ice Hockey ,Soccer, Wrestling	Limited Contact/Impact □ Baseball, Basketball, Diving, Gymnastics, Volleyball, Skiing (Alpine & XC)
Strenuous No Contact □ Indoor Track, Cross Country, Tennis, Track & Field, Swimming	Non-strenuous /noncontact □ Golf Bowling

PHYSICIAN INFORMATION: Name of Physician
(Print/Type/Stamp)_____
Address:_____ Phone:_____
School Physician_____