Oyster River Cooperative School District

**OYSTER RIVER HIGH SCHOOL**

*Physical Examination Form for Athletic Participation*

**TO BE FILLED OUT BY EXAMINING PHYSICIAN:** (Existing Medical Office forms are acceptable).

Name of Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­ Age: \_\_\_\_\_ DOB: \_\_\_\_\_\_ Grade: \_\_\_\_\_

Height: \_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_ Blood Pressure: \_\_\_\_\_\_\_\_ Pulse: \_\_\_\_\_\_

Date of Last Tetanus Immunization: \_\_\_\_\_\_\_\_\_\_\_\_ Date of Last MMR: \_\_\_\_\_\_\_\_

 (Required) (Required)

(Or attach copy of current immunization record)

Allergies: \_\_\_\_ No \_\_\_\_ Yes (If Yes, please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma: \_\_\_\_\_ No \_\_\_\_ Yes (If yes, does the child use an inhaler?)\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Examination Satisfactory: Unsatisfactory: Explanation of Unsatisfactory

HEENT \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lungs \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Abdomen \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hernia \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Neurological \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Extremities \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Abnormal Findings \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have examined this student and reviewed his or her medical history. Check appropriate line:

\_\_\_\_\_\_\_ I recommend this student for athletic participation.

\_\_\_\_\_\_\_ I **do not** recommend this student for athletic participation.

Date Examined: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 20\_\_\_\_ by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Physician’s signature)

Physician’s Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This medical record is to be kept on file in the ORHS Health Office**

55 Coe Drive, Durham, NH 03824 Phone: 603-868-2375 Fax: 603-868-1355