DOCTOR'S SIGNATURE MUST BE ON BOTH SIDES OF SHEET

PHYSICAL EXAMINATION REQUIREMENTS

SCOTTSBLUFF – GERING PUBLIC SCHOOLS

(Revised February 2011)

"The Board of Education shall require evidence of a physical examination by a qualified physician with six months prior to the entrance of a child into the **beginner grade** and the **seventh grade**, or in the case **of a transfer from out-of-state** to any other grade of the local school, provided no such examination shall be required of any child whose parent or guardian shall object thereto in writing." School Law 79-214 (1999)

Each student participating in interscholastic athletics is required to have a complete physical examination (Nebraska School Activities Association requirement) to be given after May 1 of each year. This certifies that the athlete is qualified for the entire school year May 1 through the following closing day of school or the current year.

NAME:_____SCHOOL _____

ADDRESS: _____AGE_____SEX: M _____ F_____

PHYSICAL FINDINGS

Height_____ Weight _____
Blood Pressure _____Pulse _____
Vision Screening Report, if given:_____
OD _____ OS _____
With Glasses:
OD _____ OS _____
Does the student now have or previously had: _____
Diabetes_____ Seizures _____
Heart Disease _____ Ulcers_____
Hearing Loss _____ Chicken Pox___YR____
Hepatitis _____Mononucleosis _____
Asthma _____
Urinalysis (if recommended) _____
Hemoglobin (if recommended) _____

Heart _____
Thyroid _____
Lungs _____
Abdominal Organs _____
Orthopedic Exam:
Neck_____
Spine _____
Upper Extremities _____
Lower Extremities _____
Knees _____
Feet_____
Evidence of Scoliosis: NO_____YES_____
Evidence of Hernia: NO_____YES_____

RECORD OF IMMUNIZATIONS: (Please give dates – Month and Year)

DPT /HIB:	DT	HBV	POLIO
Series#1 _____/_____	Series #1 _____	Series #1_____	Series #1 _____
Series #2_____/_____	Series #2 _____	Series #2_____	Series #2 _____
Series #3 _____/_____		Series #3_____	Series #3_____
Booster #1 _____/_____	Booster #1 _____		Booster #1 _____
Booster #2 _____/_____	Booster #2 _____		Booster #2 _____

MMR #1_____MMR #2_____Measles ____ Mumps _____ Rubella _____ TB _____ Varicella #1_____ Varicella #2_____

Tdap (7th Grade only)_____ (Required as per NE State Statute)

DOES THE STUDENT HAVE ANY ALLERGIES? _____
OPERATIONS OR SIGNIFICANT INJURIES (Please List) _____
HEAD INJURIES_____
REQUIRED MEDICATION ON A DAILY OR EPISODIC ROUTINE _____
SIGNIFICANT FINDINGS AND REMARKS _____
_____

Please Check Classifications:

_____Regular: Student may participate in the regular program of physical education, recreation, intramural, athletics or related activities.

_____Adapted: Student has a condition which might risk sustaining injury from participation in the regular program or needs a special adapted program as indicated by the consulting physician. Re-examination each year.

_____ _____
Date Examining Physician

CERTIFICATION FOR INTERSCHOLASTIC ATHLETICS: (Please complete on Back)

(over)

CERTIFICATION FOR INTERSCHOLASTIC ATHLETICS

I certify that I have on this date examined this student and that on the basis of the examination requested by 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 – **EXCEPT THOSE CROSSED OUT BELOW.**

BASEBALL	FOOTBALL	SOFTBALL	VOLLEYBALL
BASKETBALL	GOLF	TENNIS	SWIMMING
CROSS COUNTRY	SOCCER	TRACK	WRESTLING-estimated weight level:_____
GYMNASTICS			OTHERS:_____

SPORTS CANDIDATES' QUESTIONNAIRE

(to be completed by parent or physician)

(Circle one)

1. **History of diabetes in family ..... YES ..... NO**
2. **History of epilepsy or other seizures disorders ..... YES ..... NO**
3. **Has had illness requiring medical attention ..... YES ..... NO**
4. **Has had illness lasting more than a week ..... YES ..... NO**
5. **Is under a physicians care now ..... YES ..... NO**
6. **Takes medication now ..... YES ..... NO**
7. **Wears glasses or contact lenses ..... YES ..... NO**
8. **Has had a surgical operation ..... YES ..... NO**
9. **Has been in hospital (except for tonsillectomy) ..... YES ..... NO**
10. **Do you know of any reason this person should not participate in sports? ..... YES ..... NO**

Please explain any "yes" answers to the above questions: _____

_____

_____

After review of the medical history and as indicated by the above record, I herewith certify that this student has passed the physical examination successfully and is physically able to participate in interscholastic athletics. I certify that I am qualified to conduct all phases of the health examination of the above named student.

Activities student should not participate in: _____

REMARKS: _____

_____

_____

_____ _____

Date Examining Physician signature

DENTAL EXAM
(Optional)

Teeth_____

_____

Cavities: _____

Hygiene:_____

Remarks: _____

_____

_____

_____

Dentist Signature

_____

Date