SELAH MEDICAL CENTER
9. E. 1st Ave. St #4
Selah, WA 98942
(509)697-8008

SCHOOL/SPORTS MEDICAL EXAMINATION
(Must be signed by parent or guardian prior to examination)

(PLEASE PRINT) School:______________________________________ Grade:__________________
Student's Name:____DOB:__________________
Address____
Parent's Name: ____ Telephone: ____________________________

1. Has had injuries requiring medical attention. YES NO
2. Has had head and/or neck injuries or loss of consciousness. YES NO
3. Has had serious illness lasting more than one week. YES NO
4. Is under a physician's care now. YES NO
5. Takes medication now. YES NO
6. Has diabetes. YES NO
7. Has allergies. YES NO
   a. Bee Stings YES NO
   b. Asthma YES NO
   c. Other-listed below YES NO
8. Wears:
   a. a)Contact lenses b)Glasses
9. Has a seizure disorder.
10. Has been in the hospital in the past year.
11. Has had a surgical operation.
12. Do you know of any reason this student should not participate in sport.

Please explain any YES answer(s) to the above question:____
____

Parent Signature: ____

--DOCTOR USE ONLY--
Age:_______________ BP: _________________ Height: _______________ Weight:______________ VA: Right 20/____________
Left 20/___________

	NORMAL	COMMENT
EYES	_________	___________
EARS	_________	___________
RESPIRRATORY	_________	___________
CARDIOVASCULAR	_________	___________
ABDOMEN	_________	___________
GENITALIA	_________	___________
MUSCULOSKELETAL	_________	___________
NEUROLOGICAL	_________	___________
SKIN	_________	___________
OTHER	_________	___________

RESTRICTIONS: ____
____

I certify that I have on this date examined this student and that, on this basis of the examination 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 athletics, except those listed under RESTRICICONS above.

PHYSICIANS SIGNATURE: ____ DATE:_________________________