William S. Hart Union High School District
2019-20
MEDICAL HISTORY FORM
Must be completed by Parent/Guardian before Physician's Physical Examination

This medical history form and physical exam must be completed prior to the start of practice.

Name _____ Sex _____ Age _____ DOB _____/_____/_____

Grade _____ School _____ Sport _____

Please circle "Y" for yes, and "N" for no. (If yes, please explain)

1.	Has the student-athlete had a medical illness or injury since his/her last check-up or sport physical? Date of Incident: Type of Illness or Injury:	Y N
2.	Is the student-athlete currently taking any prescription or non-prescription (over-the-counter) medication, or using an inhaler? Type of Medication:	Y N
3.	Does the student-athlete have any allergies? (pollen, medicine, food, stinging insects, etc.) Type of Allergy:	Y N
4.	Has the student-athlete ever had a seizure? Date of Incident:	Y N
5.	Has the student-athlete ever become ill from exercising in the heat? Date of last incident:	Y N
6.	Does the student-athlete wear glasses, contacts, or dental braces?	Y N
7.	Has the student-athlete ever been diagnosed with a concussion? Date of Incidents: Please indicate the longest amount of time that the student-athlete has missed activity due to a concussion:	Y N
8.	Is there any additional pertinent medical information that coaches or physicians should know about this student- athlete? Please describe:	Y N

THIS DOCUMENT WILL BE SHREDDED IN JUNE 2020.
NEW FORMS MUST BE SUBMITTED FOR 2020-21 SCHOOL YEAR.

Student-Athlete's signature _____ Date _____

Parent/Guardian's signature _____ Date _____

William S. Hart Union High School District
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CERTIFICATE OF PHYSICAL EXAMINATION
Must be completed by a Licensed Physician (M.D.)

Name _____ DOB ____/____/____

Height _____ Weight _____ Pulse _____ BP _____/_____

Please put a " √ " as either Normal or Abnormal for all findings below. Please describe, in detail, all abnormal findings.

	Normal	Abnormal	Comments
Heart			
Pulses			
Lungs			
Neck			
Back			
Shoulder/Arm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle/Foot			
Other pertinent medical findings			

Additional comments: _____

List any restrictions and duration: _____

I hereby certify that the above-named student was examined by me on _____ (date) and found to be physically fit to engage in athletics.

Physician's signature _____

Stamp name or attach card of medical office here