



## Medical Examination - Athletics

### Parents Medical History for Athletics

Name (Student) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parents or Guardians \_\_\_\_\_

Address \_\_\_\_\_ School \_\_\_\_\_

#### PARENT:

Current status of student's health:

Allergies? Yes\_\_\_ No\_\_\_ If so, describe \_\_\_\_\_

Contact lenses, glasses, teeth braces,  
or any prosthesis (artificial tooth,  
limbs, etc.) Yes\_\_\_ No\_\_\_ If so, describe \_\_\_\_\_

Long term prescribed medication? Yes\_\_\_ No\_\_\_ If so, describe \_\_\_\_\_

Describe any other significant medical or health problems (asthma, diabetes, epilepsy, hearing condition,  
kidney problems, etc.)  
\_\_\_\_\_  
\_\_\_\_\_

Previous history of health:

Convulsions: Yes\_\_\_ No\_\_\_ If so, describe \_\_\_\_\_

Head injuries: Yes\_\_\_ No\_\_\_ If so, describe \_\_\_\_\_

Prior athletic injuries: Yes\_\_\_ No\_\_\_ If so, describe \_\_\_\_\_

Fractures: Yes\_\_\_ No\_\_\_ If so, describe \_\_\_\_\_

Serious or chronic illness: Yes\_\_\_ No\_\_\_ If so, describe \_\_\_\_\_

Describe any other significant medical or health problems \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PARENTS SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

I have read this history and certify that this student is eligible for participation in athletics in the Aurora  
Public Schools.

\_\_\_\_\_  
(Physicians Signature)

\_\_\_\_\_  
(Date)

## Physician's Medical Examination for Athletics

In order for this student to participate in the Aurora Public Schools athletic program, it is necessary that we have a complete record of health status. Please complete the following information and sign where indicated.

Height\_\_\_\_\_ Weight\_\_\_\_\_ Blood Pressure\_\_\_\_\_ UA\_\_\_\_\_ HCT\_\_\_\_\_

Check Each Item in appropriate Space

	Normal	Abnormal
Eyes		
Ears		
Nose		
Skin		
Glands		
Throat		
Heart		

	Normal	Abnormal
Lungs		
Extremities		
Hernia		
Other		

Describe any Abnormalities \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I certify that I have on this date \_\_\_\_\_ 20\_\_ examined \_\_\_\_\_  
(Month) (Day) (Year)

\_\_\_\_\_ and find him/her physically able to compete in supervised activities  
**NOT CROSSED OUT BELOW.**

BASKETBALL	GOLF	SWIMMING
BASEBALL	GYMNASTICS	TENNIS
CHEERLEADING	POMPONS	TRACK
CROSS COUNTRY	SOCCER	WRESTLING
FOOTBALL	SOFTBALL	VOLLEY BALL

List any modifications or constraints for participation  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Name, Address and Phone # of Physician

\_\_\_\_\_  
(Please Type) Physician's Signature