2023-2024 Physical Screening and Physician Authorization Form

This is not a School District sponsored event

Not printed at School District expense



Student's							Home			
Legal							Phone			
Name: Home							Number: _ Date of			
Address:							Birth:			
Training							·			
Campus Your Medical History:							_ Age: _			
		•								
	• .	•	·	opointment v			-		•	
•		•	•	revented you		•	-		Yes	No
2. Are you	allergic to a	ny medicati	on? Yes	No	(describe) _					
3. Do you h	nave any fan	nily history	of medically	/ unexplained	d or cardiac	caused suc	dden death ι	ınder age	50? Yes	No
4. Do you h	nave any fan	nily history (of Long QT	Syndrome o	r unexplaine	ed fainting o	or seizures?	Yes	No	
5. Females	Only – Dat	es of most	recent men	strual period	:					
6. Have yo	u had any in	ijuries, pain	or swelling	to the follow	ring areas? (Circle all th	at apply)			
Head	Chest	Elbows	Hands	Hips	Knees	Ankles	Neck	Arms	Shoulders	s Wrists
Fingers	Thighs	Shins	Calves	Feet	Back	Other:				
7. Do you h	nave a histor	ry of and/or	take medic	ation for any	medical pro	blem listed	below (Circ	le all that	apply)	
Viral Infections		Heart Conditions		Asthma	Easily	Easily tired		High or Low Blood Pressure		
Illness from Heat		Chest Pain		Seizures Rash or I		Hives	Fainting	High o	or Low Cho	lesterol
Difficulty Breathing		Broken Bones		Diabetes Hospitali		lization Allergies		Severe Headaches		
Difficulty	Skin Conditions		Concussion		•		_			
_	_		ussion		-		_			litions
Skin Co	nditions	Concu		Numbness	-		Surgery		other Cond	litions
Skin Co	nditions	Concu		Numbness	Joint	Pain	Surgery	Any	other Cond	
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