Trinity High School Physical Form
2021-2022

Part I.- to be completed by the Parent/ Student

Student Name:_____ **DOB:**_____ **Sex:**_____

Parent Name:_____

Home Address:_____ **Phone home:** _____
_____ **work:** _____
_____ **cell:** _____

Health History:

1. Do you have a chronic/ or on-going injury or illness? **Yes_____ No_____**

2. Do you take or prescribed any medications? **Yes_____ No_____**
-if yes please list medication and dosage:_____

3. Do you have allergies to any medication, latex, bee stings, food, etc? **Yes____ No____**
-if yes please explain and list special instructions:_____
_____

4. Do you have Diabetes? **Yes_____ No_____**
-if yes please explain:_____

5. Do you have asthma? **Yes____ No____**

6. Have you suffered any injury since last active season (sport related or not)?
Yes_____ No____

7 Do you have any other medical conditions? **Yes_____ No____**
Please explain:_____
_____

Part II.- to be completed by Physician or Healthcare Provider

Student Name: **Date of Physical** **Year of Graduation**

Height **Weight** **Blood Pressure (Sitting)**

Vision: 20/_____ **Vision: 20/_____** **Glasses: Yes_____ No_____**

			Check if Negative:
Ears:			
Skin:			
Mouth/Teeth:			
Chest:	**Murmurs**		
	Rhythm		
	Lungs		
Lymphatics:	**Cervical**		
	Axillary		
Abdomen:	**Spleen**		
	Liver		
	Tenderness		
Genitalia:			
	Hernia		
Neurological:			
Orthopedic:	**Cervical spine/back**		
	Shoulders		
	Arm/elbow/wrist/hand		
	Knees		
	Ankles		

Other from positive history: _____

Certification:
I certify that I have examined this student and find him/her medically qualified/unqualified to participate in the inter-scholastic sport listed above:

Please Circle:
Cleared for: 1. (FULL Participation) 2. (LIMITED Participation) (3.) RESTRICTED

Please List Limitations/ Restrictions:_____

_____

_____ _____
Print Name of Physician/ Healthcare Provider **Phone**

_____ _____
Physician/Healthcare Provider Signature **Date**