Name_____DOB __ __ / __ __/ __ __ __ __Male __ Female __

Current Health Issues

Allergies:

Medications	Food	Other

Y N	Epi-Pen
Y N	Asthma
Y N	Diabetes
Y N	Seizure Disorder
Other	

Physical Examination

Date of Examination __ __ / __ __/ __ __ __ __

Height	Weight	BMI	BP

Hib	
DTaP	
Polio	
Hepatitis B	
MMR	
Varicella	

Y N	Examination Deemed Normal
Y N	Immunizations Complete (Please attach)
Y N	Individual is approved to participate in competitive and physical activities.

Physician/Examiner Name Printed	
Physician/Examiner Signature	