

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.

BASEBALL	GOLF	SWIMMING
BASKETBALL	GYMNASTICS	TENNIS
CHEERLEADING	LACROSSE	TRACK
CROSS COUNTRY	POM PON	VOLLEYBALL
FOOTBALL	SOCCER	WRESTLING
	SOFTBALL	

LIST ANY MODIFICATIONS OR CONSTRAINTS FOR PARTICIPATION _____

I have read this history and certify that this student is eligible for participation in athletics in the Aurora Public Schools.
(Chiropractic signature WILL NOT BE ACCEPTED.)

 (Physician's Signature) Address & Phone # of Physician (Date)

 Type/Print Physician's Name

Physician's Stamp Must Appear Here