# GRACE INTERNATIONAL SCHOOL PHYSICAL EXAMINATION FORM

**Student's Name (Please Print):**_________________________________________ **Student's Grade:**_______

Age:______ Date Of Birth: _____/_____/_____
MONTH DAY YEAR

Father's Name (Please Print)______________________________ Mother's Name (Please Print)______________________________

*To be completed by healthcare professional:*

**Height:**______ **Weight:**______**BP:**____/____ **Resting Pulse:**_____ Vision: R 20/____ L 20/____ Corrected: Y N

| AREA | COMMENTS | INITIALS | AREA | COMMENTS | INITIALS |
|---|---|---|---|---|---|
| **Head & Scalp** | | | Hernia | | |
| **Ears** | | | Paired and Functioning Organs | | |
| **Nose & Sinus** | | | **Musculoskeletal** | | |
| **Throat, Tonsils & Adenoids** | | | Spine: Posture | | |
| **Thyroid** | | | Shoulders | | |
| **Chest/Lungs** | | | Lower Arm, Hand & Fingers | | |
| Respirations | | | Torso: Posture | | |
| **Cardiovascular** | | | Lower Body: Knee, Ankles, Feet | | |
| Heart Rate | | | **Skin** | | |
| Rhythm | | | **Central Nervous System** | | |
| Murmurs | | | Pupil Response | | |
| Other | | | Reflexes | | |
| **Abdomen** | | | Coordination | | |
| Scar, Tenderness or Masses | | | **COMMENTS:** | | |

**CLEARANCE: <u>THIS SECTION MUST BE COMPLETED, SIGNED, AND STAMPED BY THE ATTENDING PRACTITIONER</u>**

**Cleared for full activity in:**

**A. Gym activities** **Yes**____ **No**____
**If no, explain:**____________________________________________________________________________
____________________________________________________________________________

**B. <u>ALL</u> sport competition** **Yes**____ **No**____
**If no, explain:**____________________________________________________________________________
____________________________________________________________________________

**PRINTED NAME OF PRACTITIONER:** ____________________________________________________________________________

**SIGNATURE OF PRACTITIONER:** ____________________________________________ **DATE OF EXAM:**______________

GRACE INTERNATIONAL SCHOOL PHYSICAL EXAMINATION FORM

# HEALTH HISTORY QUESTIONNAIRE

***To be completed by Parent and reviewed by Physician***

1) Have you or anyone in your immediate family ever had:

| | | |
|---|---|---|
| Diabetes | **Yes** | **No** |
| Allergies | **Yes** | **No** |
| Migraines | **Yes** | **No** |
| Heart Trouble | **Yes** | **No** |
| High Blood Pressure | **Yes** | **No** |

2) Have you had or do you have:

| | | |
|---|---|---|
| Closed Head Injury | **Yes** | **No** |
| Concussion | **Yes** | **No** |
| Skull Fracture | **Yes** | **No** |
| Tendency to Lose consciousness | **Yes** | **No** |
| Seizures | **Yes** | **No** |
| Burners, Stingers, Numbness of Neck, | **Yes** | **No** |
| Shoulders, or Hands | **Yes** | **No** |

3) Have you had or do you have:

| | | |
|---|---|---|
| Temporary Loss of Vision | **Yes** | **No** |
| Impaired Vision in One Eye | **Yes** | **No** |
| To Wear Contacts or glasses | **Yes** | **No** |

4) Have you had or do you have:

| | | |
|---|---|---|
| Hearing Loss | **Yes** | **No** |
| Perforated Ear Drum | **Yes** | **No** |
| Recurrent Ear Infections | **Yes** | **No** |
| Broken Nose | **Yes** | **No** |
| Braces | **Yes** | **No** |
| Pneumonia | **Yes** | **No** |
| Mononucleosis | **Yes** | **No** |
| Hepatitis | **Yes** | **No** |

5) Have you ever been found to have only one of two functioning organs, i.e. Kidney, eye?
**Yes** **No**
Specify:_________________________________________

6) Have you had or do you have:

| | | |
|---|---|---|
| Hernia | **Yes** | **No** |
| Kidney Problem | **Yes** | **No** |
| Blood in Urine | **Yes** | **No** |

7) Have you ever had surgery? **Yes** **No**
If yes, Why?_______________________________________

8) Have you ever been told to give up any athletic activities? **Yes** **No**
If yes, Why?_______________________________________

9) Have you had or do you have:

| | | |
|---|---|---|
| Foot Problems | **Yes** | **No** |
| Shoulder Injury | **Yes** | **No** |
| Osgood-Schlatter diseas | **Yes** | **No** |
| Bone Infection | **Yes** | **No** |
| Back Injury or Frequent Backaches | **Yes** | **No** |
| Knee Injury or Recurrent Pain | **Yes** | **No** |
| Ankle Injury or Recurrent Pain | **Yes** | **No** |
| Other Joint Problems | **Yes** | **No** |

10) Have you had or do you have:

| | | |
|---|---|---|
| Anemia | **Yes** | **No** |
| Exercise Induced Asthma | **Yes** | **No** |
| Bee Sting Reaction (allergy) | **Yes** | **No** |

11) Are you allergic to any medications? **Yes** **No**
If yes specify name(s) of medications:______________________
_______________________________________________________
_______________________________________________________

12) Do you take medication regularly? **Yes** **No**
If yes, specify: ________________________________________
_______________________________________________________

13) Have you had or do you have:

| | | |
|---|---|---|
| Heart Trouble or Murmur | **Yes** | **No** |
| High Blood Pressure | **Yes** | **No** |
| Shortness of Breath | **Yes** | **No** |
| Persistent Cough | **Yes** | **No** |
| Chest Pain With Exercise | **Yes** | **No** |
| Dizziness or faintness with Exercise | **Yes** | **No** |
| Migraine Headaches | **Yes** | **No** |

If yes to any, please explain: ____________________________
_______________________________________________________
_______________________________________________________

**Please list any additional information that you feel is important To this physical examination, or that you would like the physician to know:** ___________________________________
_______________________________________________________
_______________________________________________________
_______________________________________________________
_______________________________________________________

**I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT AND COMPLETE:** Signature of Parent _______________________________ Date ______________