

**ST. DENNIS ATHLETIC ASSOCIATION
PHYSICAL EXAMINATION FORM FOR SPORTS PARTICIPATION**

NAME: _____ SEX: M _____ F _____

ADDRESS: _____

PARENT/GUARDIAN: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

DOES THIS CHILD HAVE ANY MEDICAL CONCERNS THAT MAY COMPLICATE PARTICIPATION
IN A COMPETITIVE ATHLETIC PROGRAM? BASKETBALL VOLLEYBALL YES _____ NO _____
If you marked YES, please explain: _____

MEDICAL PROBLEMS

ALLERGIES-PLEASE LIST: _____

ASTHMA/RESPIRATORY DIFFICULTY? _____ HEART PROBLEMS? _____

SEIZURE DISORDER? _____ HERNIA? _____ DIABETES? _____

PLEASE LIST ROUTINE MEDICATIONS AND/OR PHYSICAL LIMITATIONS: _____

THIS FORM MUST BE COMPLETED BY A PHYSICIAN BEFORE THE FIRST GAME

PHYSICIANS EXAM

HEIGHT _____ WEIGHT _____ BLOOD PRESSURE _____ POSTURE: _____

HEART: MURMUR _____ LUNGS _____
RHYTHM _____ BACK _____
PULSE _____ HERNIA _____

ON THE BASIS OF THIS EXAMINATION ON THIS DATE, I APPROVE THIS CHILD'S
PARTICIPATION FOR ONE YEAR IN A COMPETITIVE ATHLETIC PROGRAM.

YES _____ NO _____

PHYSICIANS NAME: _____

ADDRESS: _____

PHYSICIANS SIGNATURE: _____