

Gilford School District

Physical Exam for Athletic Participation

GHS Fax

524-3867

Actual Date of Physical Exam: _____

Note if Exam is done **PRIOR** to the end of Middle school, it will be

REQUIRED for another one to be done in High School

Name _____

DOB _____ **Age** _____ **YOG** _____

Medical Problems

Allergies

Food

Drug

Insect

Other

Asthma____ **Inhaler Yes or No**

Allergies _____ **Epi-Pen Yes or No**

Please Review Update and Attach a copy of the immunization List

Vital Signs					
Height	Weight	BMI	Pulse	Blood Pressure	Any Concerns?
Skin			Abdomen		
Acne			Tinea		
Mouth			Genitalia (Males)		
Caries			Orthodontia		
Eyes			Tanner Maturity		
Pupils			1 2 3 4 5		
Glasses					
Contacts					
Ears					
Perforation					
Discharge					
Lungs			Heart		
Air Entry			Murmur/rhythm		
Wheezing			Syncopal Episodes		
Hx Asthma			Family history early sudden cardiac death		
Musculoskeletal System			Musculoskeletal System		
N-Normal A-Abnormal 1__2__3__4__			5__6__7__8__		
1) Observe facies/body symmetry/spine			5) Spread fingers and make fist		
Look for asymmetry/Marfans/Scoliosis			Symmetry of fingers/old injuries		
2) Rotate Head			6) Touch floor w/ fingers w/o bending knees		
Cervical Spine Mobility			Hip mobility/scoliosis/hamstrings		
3) Shrug shoulders and abduct shoulders			7) "Duck" walk 4 steps		
Trapezius and Deltoid Strength			Knee flexibility/ankle instability		
4) Put hands behind head			8) Raises self on heel and toes		
ROM of shoulders and elbows			Ankle symmetry		
Full participation Recommended Yes or No If not Please indicate why_____					
Health Care Provider Name_____					
Full Signature _____ Date _____					
Address _____					

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