

YORK PREPARATORY ACADEMY ATHLETIC PHYSICAL FORM

Expiration Date *(for Athletic Office use only)* _____

I. STUDENT INFORMATION SECTION (Please Print) Sport(s) _____

Name _____ o Male o Female Date of Birth _____
 Home Phone _____ School Year _____ Grade _____
 Address _____

Parent's/Guardian's Name _____ Work Phone # _____
 Parent's/Guardian's Name _____ Work Phone # _____

<u>Check Yes or No</u>	<u>Yes</u>	<u>No</u>
Family member under 50 - heart attack or heart problems?	o	o
Medications currently being taken? What?	o	o
Medical conditions currently under treatment.	o	o
Allergies (drugs/food/clothing/medications/insects/ice)?	o	o
Have you ever had an illness, condition or injury that: required hospital overnight, emergency room, x-rays? required an operation?	o	o
caused you to see a doctor?	o	o
caused you to miss several games or practices?	o	o
Birth deformities (one eye, one kidney, etc.)?	o	o
Any permanent deformity or disability?	o	o
Mental disorder or convulsions?	o	o
Fractures or other disabling injuries?	o	o
Have you ever "passed out" or been "knocked out" ?	o	o

II. PHYSICAL BY A LICENSED STATE MEDICAL DOCTOR

Physician's Notes: _____

BP _____ Pulse _____ Height _____ Weight _____
 Skin _____ Eyes/Mouth _____
 Chest - Heart - Murmurs - Rhythm _____
 Lungs _____
 Abdominal Exam _____
 Spine _____
 Upper Ext. Left _____ Right _____
 Lower Ext. Left _____ Right _____
 Doctor's disposition: Cleared for Practice/Games _____
 Requirements _____

Physician Signature _____ Date _____
 Please Stamp Physician's Name/Address/Phone: _____