

## REPORT OF PHYSICAL EXAMINATION

STUDENT \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_

A. IMMUNIZATION HISTORY: Give dates of immunizations. NAME OF EXAMINER \_\_\_\_\_

VACCINE	ENTER DATE EACH IMMUNIZATION WAS GIVEN				
DIPHTHERIA - TETANUS - PERTUSSIS (DTP)					
- OR - TETANUS - DIPHTHERIA (Td, DT)					
POLIO					
HAEMOPHILUS INFLUENZAE TYPE b** (ENTER MONTH, DAY, YEAR)					
MEASLES* (ENTER MONTH, DAY, YEAR)			Written evidence of laboratory tests showing immunity to measles, mumps, and rubella is acceptable.  Attach written proof to this certificate or record test results and dates in the boxes at left.		
MUMPS* (ENTER MONTH, DAY, YEAR)					
RUBELLA* (ENTER MONTH, DAY, YEAR)					

URINALYSIS: \_\_\_\_\_

HGB/HCT: \_\_\_\_\_

(OPTIONAL)

TB SKIN TEST: TYPE \_\_\_\_\_

DATE GIVEN: \_\_\_\_\_

RESULT: \_\_\_\_\_

B. HEALTH HISTORY: (Include significant illnesses such as rubeola, operations, injuries, chronic or recurring illness, allergies, or pertinent developmental history.)

C. SCREENING TESTS: (If performed in physician's office)

VISION: WITHOUT GLASSES R. \_\_\_\_\_ L. \_\_\_\_\_ Hearing: HOW TESTED \_\_\_\_\_

WITH GLASSES R. \_\_\_\_\_ L. \_\_\_\_\_ RESULTS \_\_\_\_\_

D. PHYSICAL EXAMINATION: (Code - satisfactory = √; not satisfactory = x; not examined = o)

HEIGHT: \_\_\_\_\_ WEIGHT \_\_\_\_\_ B/P \_\_\_\_\_ Heart \_\_\_\_\_ PULSE \_\_\_\_\_

Appearance \_\_\_\_\_ Chest/Lungs \_\_\_\_\_

Nutrition \_\_\_\_\_ Abdomen \_\_\_\_\_

Head/Neck \_\_\_\_\_ Genitalia \_\_\_\_\_

Eyes \_\_\_\_\_ Lymph Nodes \_\_\_\_\_

Ears \_\_\_\_\_ Skin \_\_\_\_\_

Nose/Throat \_\_\_\_\_ Skeletal/Scoliosis \_\_\_\_\_

Mouth/Teeth \_\_\_\_\_ Neurologic \_\_\_\_\_

SUMMARY OF FINDINGS, LIMITATIONS AND RECOMMENDATIONS: \_\_\_\_\_

CURRENT MEDICATIONS: (If needed at school, complete permission form.) \_\_\_\_\_

E. PHYSICAL EDUCATION RESTRICTIONS: \_\_\_\_\_

DATE: \_\_\_\_\_ PHYSICIAN'S SIGNATURE \_\_\_\_\_

ADDRESS \_\_\_\_\_

## ATHLETIC DEPARTMENT

BOULDER VALLEY SCHOOL DISTRICT RE-2/BOULDER COUNTY HEALTH DEPARTMENT  
SCHOOL HEALTH PROGRAM

## STATEMENT BY PHYSICIAN FOR ATHLETIC PARTICIPATION

I hereby certify that I have examined \_\_\_\_\_ and that the student was found physically fit to engage in middle level or senior high school baseball, basketball, cross country, football, golf, gymnastics, skiing, swimming, tennis, track and field, wrestling, volleyball, soccer, field hockey, softball. (Please cross out any sport in which student should not participate.)

Date of initial physical examination \_\_\_\_\_

Date of medical re-evaluation \_\_\_\_\_  
(Valid for 365 days unless rescinded)Physician \_\_\_\_\_  
(CHSAA requires physician's signature)

(PLEASE COMPLETE BOTTOM PORTION OF THIS FORM FOR ANY STUDENT IN GRADES 7 THROUGH 12 WHO COMPETES WITH STUDENTS FROM ANOTHER SCHOOL IN EITHER EXTRAMURALS, INTRADISTRICT OR INTERSCHOLASTIC ATHLETICS, INCLUDING SPECIAL OLYMPICS.)