

KIRKWOOD HIGH SCHOOL REPORT OF PHYSICAL EXAMINATION

The Missouri State High School Activities Association requires a yearly exam prior to participation in interscholastic athletics in grades 9 through 12. This exam must be dated on or after February 1st to be valid for the following school year.

School_____ Grade_____ M_____ F_____

Pupil's Name_____ Date of Birth_____

Address_____ Phone_____

City_____ State_____ Zip_____

Mother/Guardian_____ Work Phone_____

Cell Phone_____

Father/Guardian_____ Work Phone_____

Cell Phone_____

Physician_____ Phone_____

Exchange_____

Dentist_____ Phone_____

Exchange_____

Orthodontist_____ Phone_____

Exchange_____

Complete Immunization Records are required by state law, please attach a record from your health care provider or previous school. Month, day and year must be provided for all immunizations, including infant series.

Health History: Enter the year(s) in which your child had the following:

ALLERGIES_____ ANEMIA_____ ASTHMA_____ CHICKEN POX_____

DIABETES_____ MEASLES_____ MENINGITIS_____ MUMPS_____

RUBELLA_____ SEIZURE DISORDER_____ TUBERCULOSIS_____

HEPATITIS A_____ B_____ C_____

Health Information: Please list any allergies, injuries, operations, serious illness, heart conditions, vision problems, hearing loss, and/or any other health information you feel would be helpful

Is your child on medication at home? (please list): _____

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Is your child currently under medical care? (please list): _____

NOTE: PHYSICIAN TO COMPLETE THIS SECTION.

Physical Findings:

Height_____	Weight_____	Pulse_____
Blood Pressure_____	Nutrition_____	Skin_____
Scalp_____	Teeth_____	Gums_____
Nose_____	Throat_____	Ears_____
Eyes_____	Glasses/Contacts_____	Heart_____
Lymph_____	Lungs_____	Ortho_____
Scoliosis_____	Abdomen_____	Genitalia_____
Reflexes_____	Urine_____	Hernia_____

Significant concerns: _____

Can pupil carry a full program of school work? YES _____ NO _____

Should physical activity be restricted? YES _____ NO _____ Explain _____

May participate in competitive sports? YES _____ NO _____ Explain _____

(Nurse practitioners must show proof of collaborative practice)

*****LICENSED CARE PROVIDER: PLEASE SIGN AND STAMP BELOW*****

Signature, Title

Date

Stamp

Phone

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