

TORRANCE HIGH SCHOOL PHYSICAL SCREENING FORM

SPORT: _____ SCHOOL: TORRANCE HIGH DATE: _____

PRINT: Last Name First Name M.I. Grade Age Date of Birth

Address _____ City _____ Zip Code _____

HEALTH HISTORY (To be completed by student or parent):

Check and give as much information as possible **Y = yes, N = no**

Heart Trouble High Blood Pressure Asthma Diabetes
 Kidney Problems Head Trauma Seizures Other (List below)

History of any previous injuries, fractures, serious illnesses or operations (Give year of problem) _____

Current medications Allergies Last Tetanus Immunization

Signature of Parent or Guardian: _____

PHYSICAL EXAMINATION (To be completed by physician):

Height: _____ Weight: _____ Temp: _____ Blood Pressure: _____ Pulse: _____ Respirations: _____

Visual Acuity: O.D. ___/___ O.S. ___/___ () Corrected () Uncorrected L.M.P. _____

() Chest Pain () Extreme S.O.B. () Dizziness () Fatigue () Palpitations () Sudden Death of Family Member

	NORMAL	10. MUSCULOSKELETAL, ROM, STRENGTH	
1. EYES		NECK	
2. EARS, NOSE, THROAT		SPINE	
3. MOUTH AND TEETH		SHOULDERS	
4. NECK		ARMS/HANDS	
5. CARDIOVASCULAR		HIPS	
6. CHEST AND LUNGS		THIGHS	
7. ABDOMEN		KNEES	
8. SKIN		ANKLES	
9. GENITALIA-HERNIA(MALE)		FEET	
		11. NEUROMUSCULAR	

ABNORMAL FINDING: _____

RECOMMEND: () Full Activity, No Restrictions Recommend: () Vision Evaluation () Tetanus Booster
 () Accept, Restrictions: () No contact sports () Other: _____
 () Not Participate

EXAMINING PHYSICIAN: _____ License#: _____ Date: _____

Address: _____ **Doctor's Stamp here:**

Phone #: _____