Aurora
Public Schools
Aurora, Colorado 80011

Medical Examination - Athletics

Parents Medical History for Athletics

Name (Student)_____ Date of Birth _____

Parents or Guardians_____

Address_____ School _____

PARENT:

Current status of student's health:

Allergies? Yes___ No___ If so, describe_____

Contact lenses, glasses, teeth braces, or any prosthesis (artificial tooth, limbs, etc.) Yes___ No___ If so, describe_____

Long term prescribed medication? Yes___ No___ If so, describe _____

Describe any other significant medical or health problems (asthma, diabetes, epilepsy, hearing condition, kidney problems, etc.)

_____

_____

Previous history of health:

Convulsions: Yes___ No___ If so, describe _____

Head injuries: Yes___ No___ If so, describe_____

Prior athletic injuries: Yes___ No___ If so, describe_____

Fractures: Yes___ No___ If so, describe_____

Serious or chronic illness: Yes___ No___ If so, describe_____

Describe any other significant medical or health problems_____

_____

_____

PARENTS SIGNATURE_____ Date_____

I have read this history and certify that this student is eligible for participation in athletics in the Aurora Public Schools.

_____ _____

(Physicians Signature) (Date)

District form 1134)Revised 3/92)

Physician's Medical Examination
for Athletics

In order for this student to participate in the Aurora Public Schools athletic program, it is necessary that we have a complete record of health status. Please complete the following information and sign where indicated.

Height_____ Weight_____ Blood Pressure_____ UA_____ HCT_____

Check Each Item in appropriate Space

	Normal	Abnormal
Eyes		
Ears		
Nose		
Skin		
Glands		
Throat		
Heart		

	Normal	Abnormal
Lungs		
Extremities		
Hernia		
Other		

Describe any Abnormalities_____

_____

_____

I certify that I have on this date _____ _____ 20___examined_____
(Month) (Day) (Year)

_____and find him/her physically able to compete in supervised activities
NOT CROSSED OUT BELOW.

BASKETBALL	GOLF	SWIMMING
BASEBALL	GYMNASTICS	TENNIS
CHEERLEADING	POMPONS	TRACK
CROSS COUNTRY	SOCCER	WRESTLING
FOOTBALL	SOFTBALL	VOLLEY BALL

List any modifications or constraints for participation

_____

_____

_____

Name, Address and Phone # of Physician

_____

(Please Type) Physician's Signature