KEHILLAH JEWISH HIGH SCHOOL

ATHLETIC PROGRAM HEALTH EXAMINATION FORM

(Give this to the doctor to complete during student athlete's physical exam)

Please return all forms to Ryan Greenfield by mail, by dropping them off at the front desk of the school during normal summer business hours (10:00am – 4:00pm), or by e-mail to Ryan Greenfield at RGreenfield@kehillah.org. **All documents must be submitted before athletes can participate.**

Student's Name Last	First	AGE	BIRTHDATE
Address	City	Zip	Phone #

Parent/Guardian Name (please print)	Parent/Guardian Signature	Date

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ALL INFO BELOW & ON 2nd PAGE MUST BE COMPLETED BY PHYSICIAN

IMMUNIZATION RECORD

This record must be filled out by physician. It must include both month and year to be complete.
It is a requirement of the State of California that all health forms be up-to-date.

VACCINE	1st	2nd	3rd	4th	5th	Booster	
Polio (OPV or IPV)	/ /	/ /	/ /	/ /		/ /	/ /
DTP/DTaP/DT/Td (Diphtheria, tetanus and (acellular) pertussis OR tetanus and diphtheria only)	/ /	/ /	/ /	/ /		/ /	/ /
MMR (Measles, mumps, and rubella)	/ /	/ /					
Hepatitis B	/ /	/ /	/ /				
Varicella (Chickenpox)	/ /	/ /					

Last tetanus shot given _____ Date of Physical Examination _____

Have any tests or immunizations listed above caused severe illness? _____ Yes _____ No

TB SKIN TEST

Type*	Date given	Date read	mm indur	Impression
__ PPD-Mantoux			_____	__ Pos
__ Other	/ /	/ /	_____	__ Neg

*Must be Mantoux unless exception granted by local health department.

Chest X-Ray (Necessary if skin is positive.)
Film date: / / Impression: __ Normal __ Abnormal
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MEDICAL HISTORY

IF STUDENT HAS HAD ISSUES WITH ANY OF THE FOLLOWING, CHECK YES AND EXPLAIN UNDER COMMENTS. IF NOT, CHECK NO.

		COMMENTS
Seizures?	_____ Yes _____ No	_____
Speech, Hearing or Visual Difficulty?	_____ Yes _____ No	_____
Diabetes?	_____ Yes _____ No	_____
If yes, specify medication and if student brings his/her medication supplies to school.		
Heart or Pulmonary?	_____ Yes _____ No	_____
Orthopedic?	_____ Yes _____ No	_____
Allergy?	_____ Yes _____ No	_____
Does student carry a kit?	_____ Yes _____ No	_____
Is student on medication?	_____ Yes _____ No	_____

HAS THE STUDENT HAD ANY PREVIOUS DISEASES, OPERATIONS OR INJURIES THAT LIMIT HIM/HER FROM PARTICIPATION IN THE FOLLOWING ACTIVITIES?

Classroom Activities	_____ Yes _____ No	_____
Physical Education	_____ Yes _____ No	_____
Competitive Athletics	_____ Yes _____ No	_____

Is there an emotional or physical condition for which this student should remain under periodic medical observation?
_____ Yes _____ No _____

Is this student subject to fainting spells?
_____ Yes _____ No _____

Does this student have any learning disability problems?
_____ Yes _____ No _____

Height: _____
Weight: _____

Check ( ) if negative; otherwise please comment.		COMMENTS AND RECOMMENDATIONS
Skin	( )	
Muscalature	( )	
Reflexes	( )	
Posture and Body Alignment	( )	
Gait and extremities	( )	
Ears	( )	
Hearing Loss?	( )	
Eyes	( )	
Vision:	20/_____ 20/_____	
Throat (tonsils, etc.)	( )	
Lungs	( )	
Heart	( )	
Blood Pressure	_____	
Pulse Rate at Rest		
Abdomen	( )	
Hernia	( )	
External Genitalia	( )	
Teeth	( )	

DISEASES: (check if student has had history of disease or condition)

Chicken Pox	( )	Heart Disease	( )	Allergies, such as	
German measles	( )	Asthma	( )	to Penicillin	( )
Mumps	( )	Rheumatic Fever	( )	to Bee Stings	( )
Whooping Cough	( )	Epilepsy	( )	to Poison Oak	( )
Diabetes	( )				

THIS STUDENT/ATHLETE IS MEDICALLY FREE TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS: Yes _____ No _____
RESTRICTIONS: (IF ANY) _____

Physician Name & Address (print or stamp) _____

Physician Signature _____ Date _____