

OPTIMIST CLUB OF ARLINGTON
 YOUTH SPORTS PROGRAMS
 P.O. BOX 1005, ARLINGTON, TEXAS 76004-1005
 PHYSICIAN AND PARENT (OR LEGAL GUARDIAN) CERTIFICATE FOR ATHLETICS (BOY OR GIRL)
RETURN COMPLETED FORM TO YOUR COACH

Student Name _____ Male ___ Female ___ Date of Birth _____
 (Month/Day/Year)
 Family Doctor or Clinic _____
 Family Dentist _____
 Parents' Name _____
 Parents' Address _____
 Phone #s Home _____ Work _____ Cell _____
 School _____ City _____

TO BE COMPLETED BY PHYSICIAN - CIRCLE ALL THAT APPLY AND EXPLAIN

Previous History of: Allergy Head Injury Unconsciousness Bone or Joint Disease and/or Injury Heart Disease
 Hypertension Renal Disease and/or Injury Diabetes Emotional Disturbance Epilepsy

Explanation: _____

Is student routinely taking any medication? YES ___ NO ___ If yes, explain: _____

Is student allergic to any medication? YES ___ NO ___ If yes, explain: _____

Height _____ Weight _____ Blood Pressure _____ Vision: Right _____ Left _____
 Urine _____ Albumin _____ Sugar _____ Hearing: Right _____ Left _____

PHYSICAL EXAMINATION

(This examination is valid for 12 months from date shown)

	Normal	Abnormal	Not Examined		Normal	Abnormal	Not Examined
Skin.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head, Eyes, Ears, Nose, Mouth, Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen Masses.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lungs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Functions.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spleen.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hernia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explain any abnormal findings _____

I certify that on this date I have examined the above student as indicated by items checked and recommend student as being physically able to participate in supervised athletic activities as checked below:

All Sports (Football/Baseball) _____ No Sports Participation _____

Examining Physician Signature _____ Date _____

TO BE COMPLETED BY PARENT

(Check all that apply)

	YES	NO		YES	NO
Does student have a previous history of:					
A. Bleeding tendencies	___	___	O. Allergies	___	___
B. Head injuries, seizures, concussion or convulsions	___	___	P. Neck Injury	___	___
C. Asthma	___	___	Q. Bone &/or joint injury or disease	___	___
D. Hernia	___	___	R. Heart Disease	___	___
E. High blood pressure	___	___	S. Diabetes	___	___
F. Tuberculosis	___	___	T. Emotional (Psychological)	___	___
G. Sickle Cell Anemia	___	___	U. Is student taking medication regularly?	___	___
H. Kidney disease &/or injury	___	___	If yes, specify name of drug(s)		
I. Kidney, Lung, Testicle or Eye removed or non-functional	___	___	and illness requiring such drugs _____		
J. Hepatitis	___	___			
K. Rheumatic Fever	___	___			
L. Skin disease	___	___	V. Now under a physicians care?	___	___
M. Contact lenses or glasses	___	___	Name of Physician _____		
N. Has had tetanus (Date: _____) (Booster required every ten years)	___	___	W. Had a surgical operation?	___	___
Explain any yes answers: _____					