

**NATICK PUBLIC SCHOOLS • PRIVATE PHYSICIAN'S EXAMINATION FORM**

ACCORDING TO THE REGULATIONS FOR PHYSICAL EXAMINATION OF SCHOOL CHILDREN IN MASSACHUSETTS "THE SCHOOL COMMITTEE...SHALL CAUSE EVERY CHILD IN THE PUBLIC SCHOOLS TO BE SEPARATELY AND CAREFULLY EXAMINED BY A PHYSICIAN...AT INTERVALS OF EITHER THREE OR FOUR YEARS." AS A PREREQUISITE FOR PARTICIPATION IN INTERSCHOLASTIC SPORTS AT THE SECONDARY LEVEL, A STUDENT IS REQUIRED TO SUBMIT A DOCTOR'S PHYSICAL EXAMINATION REPORT. THIS FORM IS TO BE USED FOR THE FOURTH, SEVENTH AND TENTH GRADE PHYSICAL EXAMINATIONS AND FOR ALL INTERSCHOLASTIC ATHLETICS.

EXAMINATIONS FOR INTERSCHOLASTIC ATHLETICS ARE VALID FOR A CALENDAR YEAR

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ GRADE: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_ SEX: \_\_\_\_\_  
 PARENT/GUARDIAN: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

HEALTH INSURANCE/HMO \_\_\_\_\_ POLICY # \_\_\_\_\_

RECENT IMMUNIZATIONS	DATE	DATE	DATE	LABORATORY TESTS	DATE	RESULTS
TD				URINALYSIS		
POLIO				HEMATOCRIT		
MMR				HEMOGLOBIN		
OTHER				CHOLESTEROL		
				OTHER		
TUBERCULIN TEST	TYPE	RESULTS				

HISTORY--INCLUDING MAJOR MEDICAL DEVELOPMENT OR ALLERGIC PROBLEMS

ALLERGIES Y\_\_\_ N\_\_\_  
 GLASSES Y\_\_\_ N\_\_\_ CONTACTS Y\_\_\_ N\_\_\_ HEARING AID Y\_\_\_ N\_\_\_

PHYSICAL EXAMINATION DATE \_\_\_\_\_ BP / \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

SIGNIFICANT FINDINGS: \_\_\_\_\_

EYES/EARS/NOSE/THROAT \_\_\_\_\_

RESPIRATORY \_\_\_\_\_

GASTROINTESTINAL \_\_\_\_\_

CARDIOVASCULAR \_\_\_\_\_

GENTOURINARY \_\_\_\_\_

MUSCULOSKELETAL \_\_\_\_\_

NEUROLOGICAL \_\_\_\_\_

ABSENCE, DISEASE OR NON-FUNCTION OF IMPAIRED ORGAN? Y\_\_\_ N\_\_\_

EXPLAIN \_\_\_\_\_

CURRENT TREATMENT Y\_\_\_ N\_\_\_ EXPLAIN \_\_\_\_\_

CURRENT MEDICATION Y\_\_\_ N\_\_\_ EXPLAIN \_\_\_\_\_

GENERAL ASSESSMENT OF STUDENT'S HEALTH: GOOD \_\_\_\_\_ FAIR \_\_\_\_\_ POOR \_\_\_\_\_  
 ARE THERE ANY PROBLEMS THAT WOULD LIMIT OR INTERFERE WITH THIS STUDENT'S PARTICIPATION IN COMPETITIVE ATHLETICS? Y / N

EXPLAIN \_\_\_\_\_

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_ STAMP OF M.D. PHONE: \_\_\_\_\_