PART 1 - MEDICAL EVALUATION OF STUDENT FOR PARTICIPATION IN CECIL COUNTY JUNIOR FOOTBALL

To be completed by Parent or Guardian and submitted to the examining Physician before he examines the student.

Name of Student _____ Date of Birth ___/___/___ Grade: _____ School: _____ Gender: **Male / Female**
Last First Middle

Parent / Guardian Name _____ Home Address _____ Home Phone ( ) -

PERSONAL HEALTH OF STUDENT (Check correct reply)	YES	NO
1. Has had injuries or accidents requiring medical attention		
2. Has had a surgical operation		
3. Has been hospitalized		
4. Has had sickness lasting longer than one week		
5. Takes medication now or regularly		
6. Has a condition now under a physician's care		
7. Has a defect in hearing or eyesight (Wears glasses, contact lenses)		
8. Is there any reason this child should not participate in any sport?		

If you answered "YES" to any or the above questions, explain here with names and dates: _____

	YES	NO
9. Has had completed poliomyelitis immunization by injections (Salk) or vaccine by mouth (Sabin)		
10. Has had tetanus toxoid and booster inoculation		
Date of last shot: _____		
11. Has seen a dentist within the past 6 months		
12. To my knowledge the paired organs that follow are present and healthy: Eyes		
Ears (hearing)		
Lungs		
Kidneys		
Testicles or ovaries		
Arms/legs		
Fingers/toes		
13. Any Allergies		

If you answered "NO" to any of the above questions, explain here with names and dates: _____

I hereby give my consent for the above secondary school student to engage in interschool sports activities as a representative of his school, except those activities crossed out by the examining Physician on the reverse side of this form. I also give my consent for the above student to accompany the team as a member for its "away" games and contests.

I GIVE MY PERMISSION FOR THE PHYSICIAN TO COMPLETE PART II FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH AND EDUCATIONAL NEEDS IN SCHOOL AND/OR ORGANIZATION.

_____ Signature of Parent or Guardian

_____ Date

PART II - MEDICAL EVALUATION OF STUDENT FOR PARTICIPATION IN CECIL COUNTY JUNIOR FOOTBALL

(To be completed by a Physician or under his supervision)

Name of Student _____ Grade _____
Last First Middle

Significant past or present illnesses or injuries _____

PHYSICIAN'S EXAMINATION: (Circle and explain abnormal findings)

Height _____ Weight _____ Blood Pressure _____ Respirations _____ Pulse Rate _____

Eyes _____ Visual Acuity R / : L / Corrected or Un-Corrected

Ears _____ Hearing R / : L /

Nose (deformities) _____ Oropharynx _____

Teeth (cavities, dentures, braces) _____ Respiratory _____

Breasts (M & F) _____ Cardiovascular (pedal) _____

Abdomen (hernia, spleen, liver) _____ Genitalia and anus _____

Musculoskeletal _____ Neck _____

Spine (cervical, thoracic, lumbar) _____

Extremities (special attention to knees, ankles) _____

Additional explanations of abnormal findings: _____

Laboratory:

Urinalysis: Protein _____

Sugar _____

Other _____

*Tuberculin Test _____

*Chest X-ray (result/date) _____

*Other Laboratory Tests _____

*If ordered by Physician _____

Allergies _____

Neurological _____

I have on this date personally examined this student, reviewed the history and other data recorded on both sides of this form, and find this student physically able to compete in supervised activities listed below which are NOT CROSSED OUT:

Baseball	Golf	Swimming
Basketball	Gymnastics	Tennis
Cross Country	Lacrosse	Track
Field Hockey	Soccer	Volleyball
Football	Softball	

WEIGHT CERTIFICATION (Wrestling Only)

The above-named is certified for the circled minimum weight.

95 lb.	119	138	167
105	126	145	185
112	132	155	

Date _____

_____, M.D.
Physician's Signature

Physician's Address _____

Physician's Telephone _____

_____, M.D.
Physician's Name Typed

Date of Examination _____

Signature of Licensed Examiner _____