Holbrook Public Schools
Parental Physical Permission Form

Grade:________
Sport:________

Child's name:________________________ Sex ( )male ( )female Birth Date:___________________________

Address:___________________________ Tel. # ____________ School: HJSHS_______________________________

1. Has your child had any significant illness, injury, surgery or hospitalizations? Yes/No
Please list:____
2. Any current medical problem or chronic medical condition? Yes/No
Please list:____
3. Any medication taken daily or often when needed? Yes/No
Please list:____
4. Any allergic problems including asthma, nasal allergy, hives, eczema, food or drug reactions? Yes/No
Please list:____
____
5. Any significant family history? Yes/No
Please list:____
6. Any other comments about your child's health?
Please list: ____

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7. Has your child ever experienced any of these during or after exercise:
   - Dizziness or headache ( ) yes ( )no
   - Chest pain ( ) yes ( )no
   - Palpitations (fluttering chest) ( ) yes ( )no
8. Has your child ever passed out while exercising? ( ) yes ( )no

I consent to have the School Physician perform a physical exam on my child.

Signature of parent/guardian____Date:_______________

*****************************For Physician's Use Only********************************

Physical Examination
Hgt:_______________in___(_____%) Wgt:_____________lbs__(______%) BMI ________________ BP: ____________
(Check = Normal/If abnormal, please describe.)

☐ General ___________ ☐ Lungs _____________ ☐ Extremities _____________ ☐ Skin _____________

☐ Heart _____________ ☐ Neurologic _____________ HEENT _____________ ☐ Abdomen _____________

☐ Dental/Oral ______________ ☐ Genitalia _____________ ☐ Other _____________

Screening:	Pass	Fail		Pass	Fail		Pass	Fail
Vision: Right Eye	☐	☐	Hearing: Right Ear	☐	☐	Postural Screening	☐	☐
Left Eye	☐	☐	Left Ear	☐	☐			
Stereoposis	☐	☐						

☐ Yes ☐ No **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:** ____
____

The entire examination was normal**:** ☐

Signature of Examiner ***Circle*** **- MD, DO, NP, PA** Date