

- 0 No Defect
- ✓ Slight Defect
- X Marked Defect

Illinois Elementary School Assn.

Physician's Certificate for Athletes

NAME _____ SCHOOL _____ BIRTHDATE _____ GRADE _____

ADDRESS _____ PHONE _____ - _____ - _____

REQUIRED:		RECOMMENDED	
MEDICATIONS		URINE: Spec. Gra.	
HEIGHT		Albumen	
WEIGHT		Sugar	
CURRENT MEDICAL PROB		Casts	
HEART: Murmur		TONSILS	
Rhythm		NOSE AND THROAT	
Blood Pressure		GLANDS	
RATE: Normal		EARS: Right	
After 15 Hops		Left	
After 2 Min.		TEETH	
HERNIA		EYES Right	
LUNGS: Percussion		Left	
Auscultation		BLOOD TESTS:	
ORTHOPEDIC: Feet		PAST ILLNESSES, INJURIES, ALLERGIES:	
Spine			
GEN. POSTURE			

**IN THE SPACE BELOW, INDICATE ATHLETIC ACTIVITIES
IN WHICH STUDENT SHOULD NOT PARTICIPATE:**

EXAM BY:

_____ **M.D.**

EXAM DATE _____

PARENT SIGNATURE _____

DATE _____

*Physical examination must be done annually.
Each exam is good for a one-year period.*