TO BE COMPLETED BY PARENT

Participant's Name _____ Birthdate:_____

Parent's Name:_____

Telephone #: _____

Family Doctor: _____

PAST MEDICAL HISTORY	Yes/No
1.Presently taking medication	1.___/___
2.Alergic to medicine, foods, etc.	2.___/___
3.Wears glasses, contact lenses, Hearing aid, dentures	3.___/___
4.History of braces, chipped teeth, bridges	4.___/___
5.Has ongoing medical problem	5.___/___
6.Had serious or significant illness in past	6.___/___
7.Any past surgical operations	7.___/___
8.Any past injuries, accident requiring Medical help	8.___/___
9.Any past injuries directly related to sports	9.___/___
10.Any hospitalization not explained above	10___/___
11.Any know deformities (such as curvature Of back, heart problems, one kidney, Blindness in one eye, etc.)	11.___/___
12.Any serious family illness (such as diabetes, Bleeding disorders, heart attack before age 50, etc.)	12.___/___

REVIEW OF SYSTEMS
(PLEASE CHECK IF THERE ARE ANY PROBLEMS WITH THE FOLLOWING)

___Skin	___Abdomen
___Head	___Back
___Eyes	___Genital
___Ears	___Nose
___Shoulders,arms	___Neck
___Mouth/throat	___Hips,legs,feet
___Lungs	___Heart
____Muscle Strength	

If yes, please explain (what, where, when)_____

_____

I certify that the above information is correct to the best of my knowledge: _____
PARENT'S SIGNATURE

TO BE COMPLETED BY PHYSICIAN

HEIGHT_____ WEIGHT_____

	NORMAL / ABNORMAL		NORMAL / ABNORMAL
1.GENERAL	_____/_____	5.HEART	_____/_____
2.NECK	_____/_____	6.ABDOMEN	_____/_____
3.SKIN	_____/_____	7.GENITALIA (INCL. HERNIA)	_____/_____
4.LUNGS	_____/_____	8.ORTHOPEDIC	_____/_____

RECOMMENDATIONS OR COMMENTS:_____

DATE OF EXAMINATION:_____PHYSICIAN'S SIGNATURE_____