ZAMA AMERICAN MIDDLE AND HIGH SCHOOL

REPORT OF PHYSICAL EVALUATION (For Official Use Only Privacy Act)

Student's Name Last ______ First ______ Birthdate ______ (mo day yr) Grade ______ Home Phone ______

Sponsor's Name ______ Last 4 digits of the Sponsor's SSN ______ Duty Phone ______ Cell phone ______

HAS YOUR CHILD HAD OR NOW HAVE: (If yes, circle and explain below)

Head injury	Heart Problems	Bleeding/Clotting disorder	Leg cramps	Eye/Vision problems
Concussion	Skipped/Racing heartbeat	Anemia	Sprain/Strain	Hearing problems
Headache	Chest Pain	Diabetes	Broken/Fractured bones	Heat stroke
Seizures	Heart murmur	Low blood sugar	Dislocated joints	Heat Exhaustion
Fainted/Dizzy	High blood pressure	Kidney problems	Back injury	Leg cramps
Knocked unconscious	Asthma/Wheezing	Hives/Rash/Itching	Neck injury	Sinus infection
Lost memory	Cough/Trouble breathing	Reaction to bee sting	Knee injury	Nosebleeds
Numbness/Tingling	Emotional disturbances	Hernia/Rupture	Ankle injury	Weight loss/gain

Explain "Yes" answers here: ______

______

______

Does your child take medication daily?	Yes No	If yes, what? ______
Has your child ever been hospitalized?	Yes No	If yes, for what? ______
Does your child have allergies (pollen, food, drug)?	Yes No	If yes, to what? ______
Has child had positive PPD (TB skin test) ?	Yes No	If yes, when? ______

PARENT OR GUARDIAN PERMISSION

I hereby give my consent for the above student to have a physical evaluation performed by local U.S. military clinic personnel, to engage in athletics at the above school in approved sports, and to accompany the team as a member on its scheduled trips. I understand that the physical evaluation will likely be conducted without my presence.

Date ______ Print Name of Guardian ______ Signature ______

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PHYSICAL EXAMINATION:

Height ______ Weight ______ BP ______ PR ______ Scoliosis: Pass Fail

Vision: (R) 20/ ______ (L) 20/ ______ Corrected: Yes ______ No ______ Hearing: (R) ______ (L) ______ Pass Fail

REVIEW OF SYSTEMS: MEDICAL	NORMAL	ABNORMAL	MUSCULOSKELETAL	NORMAL	ABNORMAL
Eyes/Ears/Nose/Throat	☐	☐	Neck	☐	☐
Heart	☐	☐	Back	☐	☐
Pulses	☐	☐	Shoulder/arm	☐	☐
Lungs	☐	☐	Elbow/forearm	☐	☐
Abdomen	☐	☐	Wrist/hand	☐	☐
Genitalia (males only)	☐	☐	Hip/Thigh	☐	☐
Lymph nodes	☐	☐	Knee	☐	☐
Skin	☐	☐	Leg/ankle	☐	☐
DENTAL	☐	☐	Foot	☐	☐

ABNORMAL FINDINGS:

______

______

______

CLEARANCE TO PARTICIPATE IN SPORTS ACTIVITIES

☐ Cleared ☐ Not Cleared

REASONS AND RECOMMENDATIONS:

______

______

______

Signature of Medical Officer ______ Date ______