

La Grande Optimist Club  
Medical Report for Students

17

**TO BE FILLED IN BY PARENT BEFORE PHYSICAL EXAM.** (Please Print)

Grade \_\_\_\_\_ (this Fall)

Students in La Grande Optimist Football must have a physical examination performed by a physician licensed by the Oregon State Board of Medical Examiners, prior to practice and competition in athletics. This policy is standard in the La Grande School District and is mandatory for all participating in middle school athletics. The examination should be performed no earlier than May of the preceding school year.

Pupil's Name \_\_\_\_\_ Sex M F Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Last) (First) (Mo) (day) (YR)

Address \_\_\_\_\_ Phone - \_\_\_\_ - \_\_\_\_  
(Street) (Town)

- |   |            |  |
|---|------------|--|
| <p>1. Past concussions Yes*__ No__ Yr__<br/>                 Past skull fractures Yes*__ No__ Yr__</p> <p>2. Neck injury Yes*__ No__ Yr__</p> <p>3. History of muscle Yr__<br/>                 bone, joint disease Yes*__ No__ Yr__</p> <p>4. Glasses or contact lenses for athletics Yes*__ No__ Yr__<br/>                 Loss or seriously impaired vision in one eye Yes*__ No__ Yr__</p> <p>5. Hearing problem Yes*__ No__ Yr__</p> <p>6. Pneumonia Yes*__ No__ Yr__</p> <p>7. Hernia Yes*__ No__ Yr__</p> <p>8. Diabetes Yes*__ No__ Yr__</p> <p>9. Rheumatic Fever Yes*__ No__ Yr__</p> <p>10. Kidney Disease Yes*__ No__ Yr__</p> <p>11. Fainting Spells Yes*__ No__ Yr__</p> <p>12. Epilepsy or other convulsive disorders or seizures Yes*__ No__ Yr__</p> | <p>13.</p> | <p>Communicable Diseases:</p> <p>German Measles (3 day) Yes*__ No__ Yr__</p> <p>Red Measles Yes*__ No__ Yr__</p> <p>Mumps Yes*__ No__</p> <p>Chicken Pox Yes*__ No__ Yr__</p> <p>Whooping Cough Yes*__ No__ Yr__</p> <p>Scarlet Fever Yes*__ No__ Yr__</p> <p>OTHER _____ Yes*__ No__ Yr__</p> <p>14 Allergies</p> <p>Asthma Yes*__ No__ Yr__</p> <p>Insects / Bee sting Yes*__ No__ Yr__</p> <p>Hay Fever Yes*__ No__ Yr__</p> <p>Poison Oak Yes*__ No__ Yr__</p> <p>Other _____ Yes*__ No__ Yr__</p> <p>15 Tonsils / Adenoids Removed Yes*__ No__ Yr__</p> <p>16 Currently taking medication or shots Yes*__ No__ Yr__</p> <p>17 Premature Birth Yes*__ No__</p> <p>18 Any other serious defect or operations Yes*__ No__ Yr__</p> |
|---|------------|--|

Parent's Comments on Yes \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(over)

(Please retain a copy of completed form for your records)

\_\_\_\_\_  
Students Name

To Be Filled by Physician

2017

**Doctor's Physical Examination**

Height \_\_\_\_\_ Blood \_\_\_\_\_ Vision with Glasses ( )  
Weight \_\_\_\_\_ Vision without Glasses ( )

Significant Illness or Injuries \_\_\_\_\_

<u>Examination</u>	<u>Satisfactory</u>	<u>Unsatisfactory</u>
Teeth	_____	_____
Hearing	_____	_____
Cardiovascular	_____	_____
Liver, Spleen, Kidneys, Hernia, Genitals	_____	_____
Extremities	_____	_____
Orthopedic / Posture	_____	_____
Neurological	_____	_____
Skin	_____	_____
Indicated Lab Tests	_____	_____
Urinalysis negative for sugar	_____	_____

Comments on unsatisfactory conditions \_\_\_\_\_

I have on this date examined the above student and recommend him / her as being physically able to participate in the supervised athletics EXCEPT FOR \_\_\_\_\_

\*This student may be permitted weight loss to make a lower weight in WRESTLING. Yes\_\_ No\_\_  
If "Yes", may lose \_\_\_\_\_ pounds

Date \_\_\_\_\_

\_\_\_\_\_  
(Signature of Examining Physician licensed by the Oregon State Board of Medical Examiners)