

Key

- ∅ No Defect
- ✓ Slight Defect
- X Marked Defect

Illinois Elementary School Assn.

PHYSICIAN'S CERTIFICATE FOR ATHLETES

If student transfers
this card should be
sent to new school.

Name _____ School _____ Grade _____ Birth Date _____

REQUIRED:	20____	20____	20____	20____	RECOMMENDED	20____	20____	20____	20____
MONTH-DAY					URINE: Spec. Grav.				
HEIGHT					Albumen				
WEIGHT					Sugar				
GEN. POSTURE					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					TUBERCULIN TEST:				
Spine					OTHER DEFECTS				
CONTAGION:									

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

DATE OF EXAM: _____

PHYSICIAN SIGNATURE: _____

PHYSICIAN PRINTED NAME: _____

PHYSICIAN ADDRESS: _____

PHYSICIAN PHONE: _____

PARENT PERMISSION SECTION

Our son or daughter has our permission to take part in:

(cross out those NOT approved)

under the direction of the school during the year of

20____ - 20____

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

**The school will take reasonable care and precaution to prevent accidents,
but the school, or teachers, are not responsible if any accident
should occur in practice or games.**

I am in full accord with this agreement.

Date _____

Parent Signature _____