GENESIS

Last Name	First Name	Middle	Date of Birth	Age	Sex

Address	City	State	Zip

Parent/Guardian Name	Telephone	Cell Phone

Health History - To be completed by parent or guardian

Diseases/Chronic Illnesses	Allergies	Need Modifications
Asthma	Hay Fever	Medications
Chicken Pox	Insect Stings	Dietary
Heart Disease	Food	Special Equipment
Whooping Cough	Medications	Other
Seizures	Other	
Diabetes		

Hospitalizations:

Operations/Serious Illnesses:

Comments:

THIS SECTION TO BE COMPLETED BY PHYSICIAN

Height	Weight	BP	Pulse	Optional Hearing	Vision	Optional Urinalysis	Optional HCT/HGB	Date of last tetanus	
					Right Left Both				

	Normal	Comments		Normal	Comment
Skin			Genito-Urinary		
Ears			Gastrointestinal/Abdomen		
Eyes			Neurological		
Nose/Throat			Musculoskeletal		
Glands (Cerv)			Spinal Exam		
Mouth/Dental			Nutritional		
Cardiovascular			Girls-Menstrual Problems		
Respiratory			Mental Health		
Hernia			General Comments		

If completing for athletic eligibility, please answer the following:

1. Is this athlete physically able to participate in Interscholastic Competition ? Yes ☐ No ☐

2. Are there any restrictions placed on this athlete ? _____

3. General Condition: Excellent ☐ Good ☐ Fair ☐ Below average ☐

Signature of Examining Physician _____ Date _____