

**Father Dueñas Memorial School
PO BOX FD
Hagaña, Guam 96932**

**SPORTS PHYSICAL FORM
School Year 2010-2011**

THIS PORTION TO BE COMPLETED BY PARENTS

NAME:	GRADE:	D.O.B.:	SEX:
Home Address: _____		Tel. No. _____	
Father's Name: _____	Mother's Name: _____	Tel. No. _____	
Father's Place of Employment: _____		Tel. No. _____	
Mother's Place of Employment: _____		Tel. No. _____	
Legal Guardians: _____			
Guardian's Place of Employment: _____		Tel No. _____	

HEALTH HISTORY

Please indicate age or date of condition on the space provided below:

Anemia	Diabetes	Heart Disease	Rheumatic Fever
Hernia Rupture	Skin Problem	Chicken Pox	Hay Fever
Tuberculosis	Convulsions	Hearing Problem	Vision Problems
Asthma	German Measles	Measles	Mumps

Any head injuries? Yes No If yes, when? _____

Any fractures? Yes No If yes, when? _____

Any allergies? Yes No If yes, what? _____

Previous hospitalization? Yes No If yes, why? _____

Currently taking any medication? Yes No For what reasons? _____

If yes, what medication? _____

Handicap conditions (please explain or specify): _____

Prosthesis (please explain or specify): _____

Any medical reason why this child should not participate in Athletics? _____

ATHLETIC CLEARANCE (Parental Consent)

I hereby give my permission for the physician to examine my child so that he may obtain health clearance to participate in athletic activities. Therefore, the examining physician, Father Dueñas Memorial School, IIAAG, and the Department of Education are **not** to be held liable for any abnormalities not detected in this examination.

Permission is also granted to my child (name) _____ to participate in the athletic activities approved by the doctor as initialed below for the school year **2010-2011**.

PARENT'S SIGNATURE: _____ DATE: _____

THIS PORTION TO BE COMPLETED BY PHYSICIAN

Height _____ Weight _____ Pulse _____ Resp. _____ B/P _____ Vision: R _____ L _____

Physical Examination (remarks/recommendations): _____

Further Medical Examination is indicated: _____

All Sports Listed: _____

Cross Country _____ Football _____ Cycling _____ Bowling _____ Soccer _____ Baseball _____ Tennis _____

Basketball _____ Wrestling _____ Golf _____ Rugby _____ Paddling _____ Volleyball _____ Track & Field _____

DRUG TESTING RESULTS: _____ **Positive** _____ **Negative**

If positive, please circle one of the following:

COCAINE METHAMPHETAMINE THC

I have examined the above named student and find him physically able to participate in the following activities initiated below for the school year **2010-2011**.

Name of Examiner: _____ Clinic: _____

Address: _____

Signature: _____ Date: _____