المدرسة العالمية الامريكية
The UNIVERSAL AMERICAN SCHOOL

UAS PHYSICAL EXAMINATION
MEDICAL INFORMATION

Participant Name:	Age:	Grade:	Sex: M or F
Physician Name:	Home #:	Work #:	

PATIENT HEALTH HISTORY				TO BE COMPLETED BY PHYSICIAN				
Parents or guardian, please answer yes or no and provide details if necessary to the following questions				**Vitals**	**Satisfactory**		**Exam Comments**	**Follow Up**
	Yes	**No**	**Details**		**Yes**	**No**		
Chronic or Recurrent Illness				Height				
Hospitalization				Weight				
Operations				BP				
Taking Medication				Pulse				
Organs Missing				General:				
Heat Exhaustion				Head				
Dizziness, Fainting, Seizures				Eyes				
Knocked Out				Ent				
Wear Glasses / Contacts				Dental				
Hearing Problems				Chest				
Allergic to Medication				Heart				
Allergic to Food, Pets								
High Blood Pressure				Abdomen				
Bone, Joint, Spine Injury								
Liver, Spleen, Kidney or Skin Problems				Skin				
Experienced any heart related problems?				Extrem, Back, Neck				
Is the participant currently taking any medications? If so, list:				Comments:				

The above information is correct to the best of my knowledge. I hereby give my informed consent for the above mentioned student to participate in activities. I understand the risk of injury in athletic participation.	Sports Participation approved: _____Yes _____ No ____ Deferred Comments:____
X	**X**
Signature of Parent or Guardian / Date	Signature of Physician / Date

(Appendix B)