

NORTH ANDOVER HIGH SCHOOL
ATHLETIC DEPARTMENT
430 Osgood Street
North Andover, Massachusetts 01845

TO BE COMPLETED BY PHYSICIAN

Today's Date: _____

Name of Student: _____

Sport: _____ **Current Grade:** _____

1. Height _____ Weight _____ Blood Pressure _____
2. Significant past illness or injury: _____
3. Flexibility: _____
4. Eyes: _____
5. Respiratory: _____
6. Cardiovascular: _____
7. Liver: _____ Spleen: _____ Hernia: _____
8. Musculoskeletal: _____ Genitalia: _____
9. Neurological: _____ Skin: _____
10. Laboratory: Urinalysis: _____ Other: _____
11. Comments: _____
12. Completed Immunizations: Polio _____ Tetanus _____
Date Date

I have on this date examined this student and on the basis of the examination and the student's medical history, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities.

Date of Examination: _____ **Signed:** _____
Examining Physician

Physician's Address: _____ **Telephone No.:** _____

Please return completed form to: Athletic Director
North Andover High School