# MEDICAL EXAMINATION
# FOR SUMTER CHRISTIAN SCHOOL

DATE OF EXAM:__________ PATIENT'S NAME:________________________________

Address: ________________________________________________ DOB:____________

HEIGHT:__________ WEIGHT_________ BP____________ PULSE_____________

LUNGS________________________________________________________________

ABDOMEN______________________________________________________________

CARDIOVASCULAR_______________________________________________________

MUSCULOSKELETAL______________________________________________________

SKIN_________________________________________________________________

GENITAL______________________________________________________________

DATE OF LAST TETANUS?________________________________________________

General Comments or Recommendations:__________________________________

_____________________________________________________________________

_____________________________________________________________________

MEDICAL HISTORY: Does the patient have any of the following conditions?
(Please check all that apply.)

______ Heart problems Specific:______________________________________

______ High blood pressure Medicine used:_________________________________

______ Asthma Medicine used:_________________________________

______ Seizures Last time seizure occurred:________________________

______ Diabetes Medicine used:_________________________________

______ Medical allergies Medicines:_____________________________________

I certify that this student has been examined within the last year and is able to compete in the following sports. (Cross out any exceptions.)

Soccer Volleyball Basketball Softball Baseball Cheerleading

Signed:_________________________________ M.D. / D.O. Date:________________

Physician's name (print or type)_________________________ Phone:________________