



## Phoenix Christian Unified Schools

Senior High Junior High Elementary Preschool International  
1751 W Indian School Road, Phoenix, AZ 85015 (602) 265-4707

**THIS SECTION TO BE COMPLETED BY PARENT/GUARDIAN**

**Student's Last Name** \_\_\_\_\_ **First Name** \_\_\_\_\_ **Grade** \_\_\_\_\_

Y	N	Has this student ever had...	Y	N	Has this student ever had...	Y	N	Has this student ever had...	Y	N	Has this student ever had...
		01. Allergies			11. Epilepsy (Seizures)			21. Elbow Injury			31. Migraine Headaches
		02. Anemia			12. Fainting			22. Knee Injury/Surgery			32. Mononucleosis
		03. Arthritis			13. Operations			23. Neck Injury			33. Rheumatic Fever
		04. Asthma			14. Hearing Trouble			24. Spine Injury			34. Scoliosis
		05. Back Pain			15. Heart Murmur			25. Wrist Injury			35. Sinus Trouble
		06. Concussion			16. Hepatitis			26. Fractures			36. Sore Throats (Chronic)
		07. Loss of Consciousness			17. Hernia (Rupture)			27. Joint Pain			37. Tuberculosis
		08. Diabetes			18. Hives			28. Kidney Trouble			38. Valley Fever
		09. Eczema			19. Dislocations/Sprains			29. Knocked Out			39. Other
		10. Emotional Problems			20. Ankle Injury			30. Menstrual Cramps			

**PLEASE EXPLAIN COMPLETELY EVERY "YES" ANSWER ABOVE:**

\_\_\_\_\_

List all expected Sports participation: \_\_\_\_\_

**PHYSICAL EXAM REQUIRED OF ALL 6th—12th GRADE STUDENTS  
TO BE COMPLETED BY THE PHYSICIAN AFTER MARCH 1ST FOR THE FOLLOWING SCHOOL YEAR**

Height \_\_\_\_\_ Eyes \_\_\_\_\_ R \_\_\_\_\_ L (without correction)  
 Weight \_\_\_\_\_ Eyes \_\_\_\_\_ R \_\_\_\_\_ L (with corrective lens)  
 Heart \_\_\_\_\_ Lungs \_\_\_\_\_ Blood Pressure (right arm, sitting) \_\_\_\_\_  
 Abdomen \_\_\_\_\_ Hernia \_\_\_\_\_ Pulse/Resting \_\_\_\_\_ 2 Min \_\_\_\_\_  
 Spine/Neck \_\_\_\_\_ Hip/Knee \_\_\_\_\_ Ankle/Feet \_\_\_\_\_ Shoulder \_\_\_\_\_  
 Elbow/Hands \_\_\_\_\_ Genitalia \_\_\_\_\_ Lymphatics \_\_\_\_\_  
 Other \_\_\_\_\_

**NOTE: If an immunization is administered during this exam, please attach a copy of the Patient Vaccination Record.**

I certify that I have, on this date, personally examined the above student and that I have found no medical reason why this student should be disqualified from participating in all supervised athletics and physical education classes and activities except as specifically noted below:

\_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Physician: \_\_\_\_\_  DO  MD

Physician's Address : \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_