

PRIVATE PHYSICIAN FORM
CERTIFICATION FOR PARTICIPATION IN INTERSCHOLASTIC SPORTS (Upper Dublin High School)

NAME: (Print clearly) _____, _____ GRADE: _____
Last name First name

FALL SPORT: _____ *DATE: ___/___/___ HGT: _____ WGT: _____ LBS
WINTER SPORT: _____ **DATE: ___/___/___ HGT: _____ WGT: _____ LBS
SPRING SPORT: _____ **DATE: ___/___/___ HGT: _____ WGT: _____ LBS

*Fall sports exams MUST be administered after JUNE 1

**Winter and Spring SPORTS PHYSICAL DATES must be within 4-6 weeks of the start of practice.

BLOOD PRESSURE ___/___

PHYSICAL EXAMINATION FINDINGS

EYES (VISION) 20/___ 20/___ GLASSES/CONTACTS 20/___ 20/___

EARS _____

NOSE, THROAT _____

SKIN: _____

TEETH: _____

HEART/ LUNGS: _____

ABDOMEN: _____

SKELETAL: _____

NEURO-MUSCULAR: _____

MALE GENITALIA: _____

This student is physically fit to play interscholastic sports:

FALL Certification by physician: _____ phone # _____

WINTER Certification by physician: _____ phone # _____

SPRING Certification by physician: _____ phone# _____

If the athlete is **wrestling**, please CIRCLE the lowest weight classification at which he is permitted to wrestle:

103 112 119 125 130 135 140 145 152 160 171 189 275

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