

Lemont-Bromberek Combined School District 113A  
**Certificate of Physical Fitness for  
 Participation in Athletics/Activities**

Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_

Grade: \_\_\_\_\_

School Year: \_\_\_\_\_

Sex:            M    F

**HEALTH HISTORY            TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)			MEDICATION (List all prescribed or taken on a regular basis.)			
Diagnosis of asthma?	Yes	No	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No
Child wakes during the night coughing	Yes	No		Yes	No	
Birth defects?	Yes	No	Hospitalizations? When? What for?	Surgery? (List all.) When? What for?	Yes	No
Developmental delay?	Yes	No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No	Serious injury or illness?	TB skin test positive (past/present)?	Yes*	No
Diabetes?	Yes	No				
Head injury/Concussion/Passed out?	Yes	No	TB disease (past or present)?	Tobacco use (type, frequency)?	Yes*	No
Seizures? What are they like?	Yes	No				
Heart problem/Shortness of breath?	Yes	No	Alcohol/Drug use?	Family history of sudden death before age 50? (Cause?)	Yes	No
Heart murmur/High blood pressure?	Yes	No				
Dizziness or chest pain with exercise?	Yes	No	Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate    Other			
Eye/Vision problems? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor						
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Other concerns?			
Ear/Hearing problems?	Yes	No	Information may be shared with appropriate personnel for health and educational purposes. Parent/Guardian Signature _____ Date _____			
Bone/Joint problem/injury/scoliosis?	Yes	No				

**TO BE COMPLETED BY THE MD/DO/APN/PA:**

**Physical Examination Requirements**      HEIGHT \_\_\_\_\_      WEIGHT \_\_\_\_\_      BMI \_\_\_\_\_      B/P \_\_\_\_\_

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs
Skin			Endocrine	
Ears			Gastrointestinal	
Eyes	Normal    Yes <input type="checkbox"/> No <input type="checkbox"/> Amblyopia    Yes <input type="checkbox"/> No <input type="checkbox"/>	Objective screening    Yes <input type="checkbox"/> No <input type="checkbox"/> Result _____ Referred to Ophthalmologist/Optomcrist    Yes <input type="checkbox"/> No <input type="checkbox"/>	Genito-Urinary	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal examination	
Cardiovascular/HTN			Nutritional status	
Respiratory			Mental Health	
NEEDS/MODIFICATIONS required in the school setting			DIETARY Needs/Restrictions	
SPECIAL INSTRUCTIONS/DEVICES    e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup				
MENTAL HEALTH/OTHER    Is there anything else the school should know about this student? If you would like to discuss this student's health with school or school health personnel, check title: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> Principal				
EMERGENCY ACTION    needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe.				
On the basis of the examination on this day, I approve this child's participation in _____ (If No or Modified, please attach explanation.)				
PHYSICAL EDUCATION    Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>		INTERSCHOLASTIC SPORTS (for one year)    Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>		
Physician/Advanced Practice Nurse/Physician Assistant performing examination				
Print Name _____		Signature _____		Date _____
Address _____			Phone _____	