

IMMANUEL LUTHERAN SCHOOL  
Bay City, Michigan

HEALTH APPRAISAL FOR ATHLETIC PROGRAM PARTICIPATION  
(required annually - after June 15 and before participation  
in any interscholastic programs in a particular year)

School Year \_\_\_\_\_ Name of Student \_\_\_\_\_

Section I - Health History (to be completed by parent)

Is your child having any of the problems listed below?

- |   |     |    |
|---|-----|----|
| 1. Allergies or reactions                                     | Yes | No |
| 2. Hay fever, asthma, or wheezing                             | Yes | No |
| 3. Eczema or frequent skin rashes                             | Yes | No |
| 4. Convulsions or seizures                                    | Yes | No |
| 5. Heart trouble  | Yes | No |
| 6. Diabetes   | Yes | No |
| 7. Frequent colds, sore throats, earaches (4 or more per yr.) | Yes | No |
| 8. Trouble with passing urine or bowel movements              | Yes | No |
| 9. Shortness of breath  | Yes | No |
| 10. Menstrual problems  | Yes | No |
| 11. Other _____   | Yes | No |

Please explain any problem areas identified above: \_\_\_\_\_

Does your child take any medication regularly? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, what medication? \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Note Any child who becomes seriously ill or is hospitalized between the time his/her physical examination was given and the time when a particular sport season begins is required to obtain written permission from his/her physician before he/she can participate in either practices or games during that season.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Section II - Physical Examination (to be completed by physician)

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Heart Rate \_\_\_\_\_

Essential Findings Deviating from Normal: \_\_\_\_\_

Recommendation and Restrictions:

I have examined the student named above, and I believe that this person's physical condition is such that he/she may participate fully in the interscholastic athletic program of Immanuel Lutheran School, with the following restriction(s) recommended: \_\_\_\_\_

Examiner's Signature \_\_\_\_\_ Date \_\_\_\_\_

Degree or  
Examiner's Name (Print) \_\_\_\_\_ License \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_