UNITED FRIENDS SCHOOL ATHLETIC PHYSICAL FORM
(Please PRINT Using Blue or Black Ink)

PHYSICIAN'S CERTIFICATE

In accordance with the P.I.A.A. By-Laws, Article V, Section I, I have examined the general physical condition of

_____ a pupil of United Friends School, and find the said pupil to be physically fit to participate in athletic contests with members of school teams in the sport(s) and during the sports season(s) as indicated by the date of the examination and by my signature.

SPORT	DATE OF EXAM	PHYSICIAN'S SIGNATURE
CROSS COUNTRY		
FIELD HOCKEY		
FOOTBALL		
GOLF		
SOCCER (B)		
TENNIS (G)		
VOLLEYBALL (G)		
BASKETBALL		
INDOOR TRACK		
SWIMMING		
WRESTLING		
BASEBALL		
SOCCER (G)		
SOFTBALL		
TENNIS (B)		
TRACK		
VOLLEYBALL (B)		

Height _____ Weight _____ BP _____ Pulse _____
Urinalysis: Sugar _____ Albumin _____

I hereby certify for the pupil named above to wrestle at the following minimum weight class during the current wrestling season: (circle one) SENIOR HIGH (13 Weight Classes):
103 lbs 112 1bs 119 1bs 125 lbs 130 lbs 135 lbs
140 lbs 145 lbs 152 lbs 160 lbs 171 lbs 189 lbs 275 lbs
Note: Minimum weight for a 275 lb. contestant is 188 lbs.

Physician's Signature _____

BY-LAWS
Article V, Section I Physical Examination Necessary Before Pupil Begins Practice. No pupil shall be eligible to represent his high school in any interscholastic athletic contest unless he has been examined by a licensed physician of medicine or osteopathic medicine, a certified school nurse practitioner, or a physician assistant before his first sports season of that academic year, and the physician, certified school nurse practitioner, or physician assistant has signed the P.I.A.A. Physician's Certificate. Before each subsequent sports season of the same academic year, he shall be re-examined or certified by a licensed physician of medicine or osteopathic medicine, a certified school nurse practitioner, or a physician assistant that his condition is satisfactory before he commences to train or practice the intended sport, and the physician, certified school nurse practitioner, or physician assistant shall sign the P.I.A.A. Physician's Certificate.

THE EXAMINATION FOR FALL SPORTS SHALL NOT BE GIVENEARLIER THAN JUNE 1. The examination, re-examination or certification for all other sports shall not be given earlier than six weeks prior to the beginning of practice for each applicable sport

Athlete's Name: _____

If YES, Please Explain on the Lines Provided

1. Do you or your family have a history of heart conditions?	Yes / No
2. Do you or your family have a history of diabetes?	Yes / No
3. Have you ever experienced an epileptic seizure or been diagnosed with epilepsy?	Yes / No
4. Have you ever suffered from asthma?	Yes / No
If YES, is your asthma exercise related?	Yes / No
5. Have you ever had any significant illnesses or surgeries?	Yes / No
6. Have you ever had a concussion?	Yes / No
7. Have you ever injured your neck?	Yes / No
8. Have you ever been hospitalized?	Yes / No
9. Do you have any allergies?	Yes / No
10. Do you currently wear glasses or contacts?	Yes / No
If YES, what was the date of your last eye exam?	_____
11. Are you currently taking any medication? If YES please list below.	Yes / No

_____
_____
_____
_____