ZAMA AMERICAN MIDDLE AND HIGH SCHOOL

REPORT OF PHYSICAL EVALUATION (For Official Use Only Privacy Act)

_____ Birth date_____ Grade_____ Home Phone_____
Student's Name Last First mo day yr

_____ Last 4 digits of the Sponsor's SSN_____ Duty Phone_____
Sponsor's Name

Cell phone _____

HAS YOUR CHILD HAD OR NOW HAVE: (If yes, circle and explain below)

Head injury	Heart Problems	Bleeding/Clotting disorder	Leg cramps	Eye/Vision problems
Concussion	Skipped/Racing heartbeat	Anemia	Sprain/Strain	Hearing problems
Headache	Chest Pain	Diabetes	Broken/Fractured bones	Heat stroke
Seizures	Heart murmur	Low blood sugar	Dislocated joints	Heat Exhaustion
Fainted/Dizzy	High blood pressure	Kidney problems	Back injury	Leg cramps
Knocked unconscious	Asthma/Wheezing	Hives/Rash/Itching	Neck injury	Sinus infection
Lost memory	Cough/Trouble breathing	Reaction to bee sting	Knee injury	Nosebleeds
Numbness/Tingling	Emotional disturbances	Hernia/Rupture	Ankle injury	Weight loss/gain

Explain "Yes" answers here: _____
_____
_____
_____

Does your child take medication daily?	Yes	No	If yes, what?_____
Has your child ever been hospitalized?	Yes	No	If yes, for what?_____
Does your child have allergies (pollen, food, drug)?	Yes	No	If yes, to what?_____
Has child had positive PPD (TB skin test) ?	Yes	No	If yes, when? _____

PARENT OR GUARDIAN PERMISSION

I hereby give my consent for the above student to have a physical evaluation performed by a local U.S. military clinic personnel, to engage in athletics at the above school in approved sports, and to accompany the team as a member on its scheduled trips. I understand that the physical evaluation will likely be conducted without my presence.

Date_____ Print Name of Guardian_____ Signature_____

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