Print Form

Seneca Valley Wrestling Association
Health and Fitness Evaluation Form

Name of Athlete: _____ Season (year): 2014

Birth Date: _____ Age:_____ Grade in Fall:_____

Address: _____
Street City Zip

Parent/Guardian: _____

Home Phone: _____ Work/Cell Phone: _____

Parent/Guardian: _____

Home Phone: _____ Work/Cell Phone: _____

Regarding the Athlete

1 Has had injuries requiring medical attention within the past year? No ☐ Yes ☐
If yes, type of injury: _____

2 Has had rheumatic fever or heart murmur? No ☐ Yes ☐

3 Has been under physician's care for illness or surgery? No ☐ Yes ☐
If yes, type of injury or surgery:_____

4 Had an immediate relative die suddenly before the age of 60? No ☐ Yes ☐

Does the athlete:
Wear Glasses? No ☐ Yes ☐ Contacts? No ☐ Yes ☐
Take Medication? No ☐ Yes ☐ If yes, what kind? _____

Hospital Preference in case of emergency: _____

To Be Completed by Physician

Physician's comments on medical history:_____

Height: _____ Weight: _____ Pulse: _____ BP: _____

Maximum Allowable Weight Loss: _____

Comments: _____

I certify that I have on this date examined this athlete and find him/her physically able to participate in Seneca Valley Wrestling Association supervised activities.

Limitations: _____

Signature: _____
Examining Physician Date

Physicals are valid for one year from the date of physical