KEY
0 No Defect
✓ Slight Defect
X Marked Defect

Illinois Elementary School Assn.

PHYSICIAN'S CERTIFICATE FOR ATHLETES

If student transfers, this card should be sent to new school.

Name_____ School_____ Birth Date_____

REQUIRED:	20___	20___	20___	20___
MONTH-DAY				
HEIGHT				
WEIGHT				
GEN. POSTURE				
HEART-Murmur				
Rhythm				
Blood Pressure				
RATE: Normal				
After 15 Hops				
After 2 Min.				
HERNIA				
LUNGS-Percussion				
Auscultation				
ORTHOPEDIC: Feet				
Spine				
CONTAGION:				

RECOMMENDED	20___	20___	20___	20___
URINE: Spec. Grav.				
Albumen				
Sugar				
Casts				
TONSILS				
NOSE AND THROAT				
GLANDS				
EARS: Right				
Left				
TEETH				
EYES: Right				
Left				
BLOOD TESTS:				
TUBERCULIN TEST:				
OTHER DEFECTS:				

IN THE SPACE BELOW, INDICATE ATHLETIC ACTIVITIES IN WHICH STUDENT SHOULD NOT PARTICIPATE:

20_____ _____

20_____ _____

20_____ _____

20_____ _____

EXAM BY:

1st : _____ M.D.

2nd : _____ M.D.

3rd : _____ M.D.

4th : _____ M.D.