

**KEY**

- O 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____	RECOMMENDED	20____	20____	20____	20____
MONTH-DAY					URINE: Spec. Grav.				
HEIGHT					Albumen				
WEIGHT					Sugar				
GEN. POSTURE					Casts				
HEART: Murmur					TONSILS				
Rhythm					NOSE AND THROAT				
Blood Pressure					GLANDS				
RATE: Normal					EARS: Right				
After 15 Hops					Left				
After 2 Min.					TEETH				
HERNIA					EYES: Right				
LUNGS: Percussion					Left				
Auscultation					BLOOD TESTS:				
ORTHOPEDIC: Feet					TUBERCULIN TEST:				
Spine					OTHER DEFECTS:				
CONTAGION:									

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.