KEY
0 NO DEFECT
✓ SUGHT DEFECT
X MARKED DEFECT

No._____

ILLINOIS HIGH SCHOOL ASSOCIATION
PHYSICIAN'S CERTIFICATE
(PRINTED 1981)

IF STUDENT TRANSFERS, THIS CARD SHOULD BE SENT TO THE NEW SCHOOL

NAME _____ ADDRESS _____ BIRTH DATE _____

REQUIRED:	YEAR	19	19	19	19	19
MONTH - DAY						
HEIGHT						
WEIGHT						
GEN. POSTURE						
HEART: Murmur						
Rhythm						
Blood Pres.						
RATE: Normal						
After 15 Hops						
After 2 Min.						
HERNIA						
LUNGS: Percussion						
Auscultation						
ORTHOPEDIC: Feet						
Spine						
CONTAGION:						

RECOMMENDED:	YEAR	19	19	19	19	19
URINE: Spec. Grav.						
Albumen						
Sugar						
Casts						
TONSILS						
NOSE AND THROAT						
GLANDS						
EARS: Right						
Left						
TEETH						
EYES: Right						
Left						

BLOOD TESTS:

TUBERCULIN TEST:

OTHER DEFECTS:

8900122

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

19_____.

19_____.

19_____.

19_____.

19_____.

EXAM. BY:

1ST: _____ M.D. Date _____

2ND: _____ M.D. Date _____

3RD: _____ M.D. Date _____

4TH: _____ M.D. Date _____

5TH: _____ M.D. Date _____

NOTE: COMMENT ON BACK OF CARD ON ANY DEFECT WHICH MIGHT BE HELPED THROUGH CORRECTIVE TREATMENT.