

Mid Atlantic Select AAU Basketball Medical Form
Physician Report
(This is to be completed by a physician)

THE INFORMATION ON THIS FORM MUST BE CURRENT WITHIN TWO YEARS

Players's Name: _____ **D.O.B** _____

Height: _____ **Weight:** _____ **Age:** _____ **Blood Pressure:** _____ **Sex:** _____

SIGNIFICANT ILLNESS AND OPERATIONS: (Check only if satisfactory, give details if not.)

Measles _____ German Measles _____ Scarlet Fever _____ Mumps _____
Chicken Pox _____ Diabetes _____ Hypertension _____ Mononucleosis _____
Convulsions _____ Asthma _____ Heart Defects/Disease _____
Bleeding/Clotting Disorders _____ Allergies _____
Other _____
Details _____

IMMUNIZATION SUMMARY: HISTORY OF ALL SHOTS TAKEN

Date & Year IMMUNIZATION BOOSTER

DPT _____ **DT** _____

TETANUS _____

POLIO OPV _____

MEASLES _____

GERMAN MEASLES _____

MUMPS _____

MANTOUX TUBERCULIN _____

HAEMOPHILUS INFLUENZA _____

HEPATITUS B _____

CURRENT EXAMINATION: (Check if satisfactory; circle if unsatisfactory and give details)

Eyes _____ Hearing _____ Heart _____ Hernia _____ Posture _____ Vision _____
Throat _____ Lungs _____ Musc/Skel _____ Genitalia _____ Ears _____ Teeth _____
Abdomen _____ CNS _____ Skin _____
Any notable conditions: (Glasses, etc.) _____
Medicine to be administered, specific dosages, and frequency _____

Physician's Summary Statement: This is to certify that I have examined this person, on this date, and found him/her to be in good physical condition. There is no evidence that he/she should not participate in all camp activities, except as stated. I have noted any restrictions, conditions, and required medications.

Signed _____ **MD Date** _____

Print Name _____

Address _____ **Telephone** _____

Mail to: Mid Atlantic Select AAU basketball

3310 Gateshead Manor Way

Silver Spring, MD 20904

Or fax to: 301-736-0277