PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION

STUDENT'S NAME _____DATE OF BIRTH _____GENDER_____AGE____

HEIGHT _____ WEIGHT _____ PULSE _____ BLOOD PRESSURE ____/_____ ; ____/____

PUPILS EQUAL_____ UNEQUAL _____

As a minimum requirement, this PHYSICAL EXAMINATION FORM must be completed prior to school athletic participation each school year.

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position			
Heart-Auscultation of the heart in the standing position			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only

CLEARANCE Date of Examination:_____

O Cleared O Cleared after completing evaluation for_____

O Not cleared for_____Reason_____

Recommendations: _____

Provider Name: _____Provider Phone Number:_____

Provider Address:_____

Provider Signature:_____

PREPARTICIPATION PHYSICAL EVALUATION
MEDICAL HISTORY

This MEDICAL HISTORY FORM must be completed annually by parent/guardian and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed or experienced any condition which would make it hazardous to participate in an athletic event.

STUDENT'S NAME _____DATE OF BIRTH _____GENDER_____AGE____
GRADE_____
HOME ADDRESS _____HOME PHONE _____
PARENTS' CELL_____
PERSONAL PHYSICIAN_____PHYSICIAN PHONE_____

In case of emergency, contact:

NAME_____RELATIONSHIP_____HOME OR CELL_____
NAME_____RELATIONSHIP_____HOME OR CELL_____

Explain any **"Yes"** answers on a separate piece of paper. Please circle questions for which you have no answer. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in practices, games or matches.

	YES	NO
1. Have you had a medical illness or injury since your last check up or sports physical?	O	O
2. Have you been hospitalized overnight in the past year?	O	O
3. Have you ever had surgery?	O	O
4. Have you ever passed out during or after exercise?	O	O
5. Have you ever had prior testing for the heart ordered by a physician?	O	O
6. Have you ever had chest pain during or after exercise?	O	O
7. Do you get tired more quickly than your friends do during exercise?	O	O
8. Have you ever experienced racing of your heart or skipped heartbeats?	O	O
9. Have you ever had high blood pressure?	O	O
10. Have you ever had high cholesterol?	O	O
11. Have you ever been told you have a heart murmur?	O	O
12. Has any family member or relative died of heart problems before age 50?	O	O
13. Has any family member or relative died of sudden unexpected death before age 50?	O	O
14. Has any family member been diagnosed with enlarged heart (Dilated Cardiomyopathy)?	O	O
15. Has any family member been diagnosed with Hypertrophic Cardiomyopathy?	O	O
16. Has any family member been diagnosed with Long QT Syndrome?	O	O
17. Has any family member been diagnosed with abnormal heart rhythm?	O	O
18. Has any family member been diagnosed with ion channelopathy (Brugada syndrome, etc.)?	O	O
19. Has any family member been diagnosed with Marfan's Syndrome?	O	O
20. Have you had a severe viral infection (myocarditis, mononucleosis, etc.) in the past year?	O	O
21. Has a physician ever denied or restricted your participation in sports for any heart problems?	O	O

Sudden Cardiac Arrest occurs in persons of all ages. The answers to questions # 4-21 will assist in determining whether additional testing may be required for your son or daughter. If you answered yes to any of these questions, please review with a health care professional whether additional testing may be necessary, including but not limited to EKG and /or ECG.

22. Have you ever had a head injury or concussion?	O	O
23. Have you ever been knocked out, become unconscious, or lost your memory?	O	O
24. Have you ever had a seizure?	O	O

25. Do you have frequent or severe headaches?	O	O
26. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	O	O
27. Have you ever had a stinger, burner, or pinched nerve?	O	O
28. Are you missing any paired organs?	O	O
29. Are you presently under a doctor's care?	O	O
30. Are you currently taking any prescription or non-prescription medication or inhalers?	O	O
31. Do you have any allergies? If yes, specify.	O	O
32. Have you ever been dizzy before or during exercise?	O	O
33. Do you currently have any skin problems (itching, acne, warts, fungus, or blisters)?	O	O
34. Have you ever become ill from exercising or working in the heat?	O	O
35. Have you ever had any problems with your eyes or vision?	O	O
36. Have you ever gotten unexpectedly short of breath with exercise?	O	O
37. Do you have asthma?	O	O
38. Do you have seasonal allergies that require medical treatment?	O	O
39. Do you use any special protective or corrective equipment?(brace, hearing aids, retainer, etc.)	O	O
40. Have you ever had a sprain, strain, or swelling after injury?	O	O
41. Have you broken or fractured any bones?	O	O
42. Have you ever dislocated any joints?	O	O
43. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	O	O
44. Do you want to weigh more or less than you do now?	O	O
45. Do you lose weight regularly to meet weight requirements for extra-curricular activities?	O	O
46. Do you feel stressed out?	O	O
47. Have you been diagnosed with or treated for Sickle Cell Trait or Sickle Cell Disease?	O	O

Females Only

48. When was your first menstrual period? (age or year) _____
49. When was your most recent menstrual period? _____
50. How much time elapses from the start of one period to the start of another? _____days
51. How many periods have you had in the last year? _____
52. What was the longest time between periods in the last year? _____days

It is understood that even though protective equipment is worn by the athlete whenever needed, the possibility of an accident still remains. Neither the Diocese of Victoria nor Nazareth Academy assumes any responsibility in case an accident occurs. The possibility of transfer of disease exists whenever blood transfer occurs. While the risk is minimal with school activities, by signature below we recognize the possibility exists relating to blood borne pathogens and the transfer of disease such as Hepatitis or HIV. If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or illness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school, the Diocese of Victoria, and any school or hospital representative from any claim by any person on account of such care and treatment of said student.
******If between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.**

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful and complete responses could subject the student in question to penalties determined by the school.

PARENT/GUARDIAN NAME (PRINT) _____DATE_____

PARENT/GUARDIAN SIGNATURE_____DATE_____

STUDENT SIGNATURE_____DATE_____

For School Use Only

This Medical History Form reviewed by:

NAME_____DATE_____

SIGNATURE_____