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2024-2025 St. John Bosco High School
PHYSICAL - MEDICAL - AUTHORIZATION FOR TREATMENT

(Please type or print)

Student's Name:_____ Birth Date:_____ Sex: Male Grade:_____ ID#_____
Last First Middle

School: St. John Bosco High School 13640 Bellflower Blvd., Bellflower, CA 90706 Tel: 562.920.1734 Place of Birth _____

Student's Address _____
Street City Zip Telephone

Parent(s) or Guardian(s) Name _____

Address (if different than student) _____
Street City Zip Telephone

Family Physician's Name, Address, Telephone _____

History

This section is to be carefully completed by the student and his parent(s) or legal guardian(s) before entering ST. JOHN BOSCO HIGH SCHOOL in order to help detect possible risks.

Explain "YES" answers below. Circle questions you don't know theanswer to.

		Yes	No
1.	Have you had a medical illness or injury since your last checkup or sports physical?	☐	☐
2.	Do you have an ongoing or chronic illness?	☐	☐
3.	Have you ever been hospitalized overnight?	☐	☐
4.	Have you ever had surgery?	☐	☐
5.	Are you currently taking any prescription or (over-the-counter) medications or pills or using an inhaler?	☐	☐
6.	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
7.	Do you think you are in good health?	☐	☐
8.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insect)?	☐	☐
9.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?	☐	☐
10.	Have you ever had a rash or hives develop during orafter exercise?	☐	☐
11.	Have you ever passed out during or after exercise?	☐	☐
12.	Have you ever been dizzy during or after exercise?	☐	☐
13.	Have you ever had chest pain during orafter exercise?	☐	☐
14.	Do you get tired more quickly than your friends doduring exercise?	☐	☐
15.	Have you ever had racing of your heart orskipped heartbeats?	☐	☐
16.	Have you had high blood pressure or high cholesterol?	☐	☐
17.	Have you ever been told you have a heart murmur?	☐	☐
18.	Has any family member or relative died of heartproblems or of sudden death before age 50?	☐	☐
19.	Is there a family history of heart problems in a close relative younger than age 50 (examples are enlarged heart, cardiomyopathy, long QT interval, abnormal EKG, abnormalheart rhythm)?	☐	☐
20.	Have you had a severe heart infection (for example, myocarditis or pericarditis)?	☐	☐
21.	Is there a family history of Marfan's Syndrome?	☐	☐
22.	Has a physician ever denied or restricted your participation in sports for any heart problem?	☐	☐
23.	Have you ever had a severe viral infection within the last month	☐	☐
24.	(for example, mononucleosis)? Have you ever had a head injury or concussion?	☐	☐
25.	Have you ever been knocked out, becomeunconscious or lost your memory?	☐	☐
26.	Have you ever had a seizure?	☐	☐
27.	Do you have frequent or severe headaches?	☐	☐
28.	Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
29.	Have you ever had a stinger, burner or pinched nerve?	☐	☐
30.	Have you ever become ill from exercising in the heat?	☐	☐

		Yes	No
31.	Do you cough, wheeze or have trouble breathing during or after activity?	☐	☐
32.	Do you have asthma?	☐	☐
33.	Do you have seasonal allergies that require medical treatment?	☐	☐
34.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐
35.	Have you had any problems with your eyes or vision?	☐	☐
36.	Do you wear glasses, contacts or protective eyewear?	☐	☐
37.	Have you ever had a sprain, strain or swelling after injury?	☐	☐
38.	Have you broken or fractured any bones or dislocated any joints?	☐	☐
39.	Have you had any other problems with pain or swelling inmuscles, tendons, bones or joints?	☐	☐

If yes, check the appropriate box and explain below.

☐ Head ☐ Upper Arm ☐ Hand ☐ Knee
☐ Neck ☐ Elbow ☐ Finger ☐ Shin/calf
☐ Back ☐ Forearm ☐ Hip ☐ Ankle
☐ Chest ☐ Wrist ☐ Thigh ☐ Foot
☐ Shoulder

40.	Do you want to weigh more or less than you do now?	☐	☐
41.	Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
42.	Do you feel stressed out?	☐	☐

43. Record the dates of your most recent immunizations (shots) for:

Tetanus_____ Measles_____
Hepatitis B_____ Chickenpox _____

DATES & DEADLINES

Physicals must take place annually during the summer. Athletes must have their physicals completed prior to the start of summer practice.

ALL PARTICIPANTS

Explain "Yes" answers here: (add attachments if necessary)

_____
_____
_____
_____

We consent to the participation of the above-named student in the interscholastic program of his school including practice sessions and travel to and from athletic contests. We also agree to emergency medical treatment as deemed necessary by designated school authorities.

_____ _____ _____
**Student Signature Above **Parent or Guardian Signature Above **Date Above

The student has family insurance_____Yes_____No; If yes, family insurance co. name, policy #: _____

NOTE: History and Consent Must be Completed Prior to Physical Examination

Modified from the form approved by the American Academy of Family Physicians, the American Academy of Pediatrics, the American Medical for Sports Medicine, the American Orthopaedic Society for Sports Medicine and the American Osteopathic Academy of Sports Medicine.

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2024-2025 St. John Bosco High School
PHYSICAL EXAMINATION (MUST BE COMPLETED BY DOCTOR)

(Please type or print)

Student's Name _____ Birth Date _____
Last First Middle

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP _____/_____

Vision R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal _____ Unequal _____

	Normal	Abnormal Findings	Initials*
MEDICAL			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Clearance

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: _____

_____

_____

☐ Not cleared for: _____ Reason: _____

_____

_____

I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to participate in supervised athletic activities (Note exceptions above).

_____ _____

Physician's Name and (stamp or print)
(Physician must be a Medical Doctor)

Physician's Signature **Date**

_____ _____

Physician's Telephone Number

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