MATER DEI CATHOLIC

REQUIRED PHYSICAL EXAMINATION FORM

(Please Note: Physical exam must be performed, signed & stamped by a physician licensed to practice in the California and written in English.

Student: _____ **Grade:** _____ **Age:** _____ **Date of Birth:** _____

Sport(s): _____ **Sex: F** _____ **M** _____

Height: _____ **Weight:** _____ **Blood Pressure:** _____ **Pulse:** _____ **Respiration:** _____

Vision: Corrected/Uncorrected **Right:** _____ **Left:** _____ **Both:** _____

REVIEW OF SYMPTOMS: Check N for Normal or A for Abnormal (if abnormal explain and date)

	N	A	Comment		N	A	Comment
Allergy to Medication:				Diabetes:			
COVID-19 infection, see below:				Seizures:			
Asthma:				Concussion:			
Family History Sudden Death:				Chest Pain:			

EXAMINATION: Check N for Normal or A for Abnormal (if abnormal explain)

	N	A	Comment		N	A	Comment
General Appearance:				Gastrointestinal:			
Ears/Nose/Throat: Head/				Genital-Urinary:			
Neck: Cardiovascular:				Muscular-Skeletal:			
Respiratory:				Skin:			
ECG: _____				Neurological:			

ECHOCARDIOGRAM: _____

PHYSICIAN RECOMMENDATIONS:

____ **Full Activity — (Cleared for unlimited participation)**

____ **Modified Activity — Please Explain:** _____

____ **No Activity Recommend:** _____

Recommend Cardiology/Ortho Consults or other: _____. I, the under-signed, have given a thorough physical examination and reviewed the medical history of the candidate. I certify that all the important medical information has been included, and the information is complete and accurate. COVID-19 infection has been shown to cause myocarditis as well as other complications in pediatric and adolescent patients. Please evaluate patient using AAP guidelines for adolescents with reported COVID-19 infection prior to clearing them for all school sports. Additional testing is required for moderate to severe infection, including an ECG and/or echo.

Physician's Signature: _____ **Date:** _____

Physician's name (print): _____ **Physician's Stamp(Required):**

Physician's address: _____

Physician's Phone #: _____

9 GRADE AND TRANSFER STUDENTS NEED TO ATTACH A COPY OF UPDATED IMMUNIZATION RECORD*