Damien Memorial School

PHYSICAL EXAMINATION FOR ATHLETES

Student's Name _____ M/F____ Date of Birth_____/_____/_____ Grade _____
(Print) Last First MI Month Day Year

Address_____ Home Phone_____ Student Resides With _____
Street No. City State Zip Code

Fall Sport _____ Winter Sport _____ Spring Sport _____

Father's/Guardian's Name _____ Bus. Phone _____ Cell or Pager_____

Mother's/Guardian's Name _____ Bus. Phone _____ Cell or Pager_____

Emergency Contact _____ Bus. Phone _____ Cell or Pager_____
Name & Relationship

Health and/or Insurance Carrier _____ Policy # _____

To be completed by Physician only

Height _____ feet & inches Weight _____lbs Blood Pressure_____/_____ Pulse_____ bpm

Vision: R 20/_____ L 20/ _____ Corrected: Yes No Pupils: Equal ____ Unequal ____

Asthma _____ (Medication Used) Diabetes _____ (Medication Used) Allergies _____ (Medication Used)

MEDICAL	NORMAL	COMMENTS	INITIALS
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart/Murmurs			
Pulses			
Lungs			
Abdomen			
Skin			
Genitalia			
MUSCULOSKELETAL			
Neck			
Back/Spine			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Calf/ankle			
Foot/toes			
Other			

Clearance:

A. Cleared for all sports _____
B. Cleared after completing evaluation/rehabilitation for _____
C. Not cleared for: ❑ Collision
❑ Contact
❑ Non contact ❑ Strenuous ❑ Moderately Strenuous ❑ Non-strenuous

Due to _____

Physician's Recommendation _____

Name of Physician _____ Date of Physical Exam _____

Address _____ Telephone _____

Signature of Physician _____ Fax Number _____

(Over)

Parent/Guardian and Student to fill out before Physical Examination

Explain "Yes" answers below. Circle question you don't know the answer to.

		Yes	No
1.	Has a doctor ever denied or restricted your participation in sports for any reason?	❑	❑
2.	Do you have an ongoing medical condition (like diabetes or asthma)?	❑	❑
3.	Are you currently taking any prescription or nonprescription (over the counter) medicines or pills?	❑	❑
4.	Do you have allergies to medicines, pollens, foods or stinging insects?	❑	❑
5.	Have you ever passed out or nearly passed out DURING exercise?	❑	❑
6.	Have you ever passed out or nearly passed out AFTER exercise?	❑	❑
7.	Have you ever had discomfort, pain or pressure in your chest during exercise?	❑	❑
8.	Does you heart race or skip beats during exercise?	❑	❑
9.	Has a doctor ever told you that you have: (circle all that apply) High blood pressure A heart murmur High Cholesterol A heart infection	❑	❑
10.	Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	❑	❑
11.	Has anyone in your family died for no apparent reason?	❑	❑
12.	Does anyone in your family have a heart problem?	❑	❑
13.	Has any family member or relative died of heart problems or of sudden death before age 50?	❑	❑
14.	Does anyone in your family have Marfan Syndrome?	❑	❑
15.	Have you ever spent the night in a hospital?	❑	❑
16.	Have you ever had surgery?	❑	❑
17.	Have you ever had an injury, like sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, list affected area: _____	❑	❑
18.	Have you had any broken or fractured bones or dislocated joints? If yes, list affected area: _____	❑	❑
19.	Have you have a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, list affect area: _____	❑	❑
20.	Have you ever had a stress fracture?	❑	❑
21.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	❑	❑
22.	Do you regularly use a brace or assistive device?	❑	❑
23.	Has a doctor ever told you that you have asthma or wheezing?	❑	❑
	EXPLAIN "YES" answers here: **(Add additional pages if necessary)**		

		Yes	No
24.	Do you cough, wheeze or have difficulty breathing during or after exercise?	❑	❑
25.	Have you ever used an inhaler or taken asthma medicine?	❑	❑
26.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	❑	❑
27.	Have you had infectious mononucleosis (mono) within the last month?	❑	❑
28.	Do you have any rashes, pressure sores, or other skin problems?	❑	❑
29.	Have you had a herpes skin infection?	❑	❑
30.	Have you ever had a head injury or concussion?	❑	❑
31.	Have you been hit in the head and been confused or lost your memory?	❑	❑
32.	Have you ever had a seizure?	❑	❑
33.	Do you have headaches with exercise?	❑	❑
34.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	❑	❑
35.	Have you ever been unable to move your arms or legs after being hit or falling?	❑	❑
36.	When exercising in the heat, do you have severe muscle cramps, or become ill?	❑	❑
37.	Has a doctor told you that you, or does someone in your family have sickle cell trait or sickle cell disease?	❑	❑
38.	Have you had any problems with your eyes or vision?	❑	❑
39.	Do you wear glasses or contact lenses?	❑	❑
40.	Do you wear protective eyewear, such as goggles or a face shield?	❑	❑
41.	Are you happy with your weight?	❑	❑
42.	Would you like to lose weight?	❑	❑
43.	Would you like to gain weight?	❑	❑
44.	Has anyone recommended you change your weight or eating habits?	❑	❑
45.	Do you limit or carefully control what you eat?	❑	❑
46.	Do you have any concerns that you would like to discuss with a doctor?	❑	❑
	FEMALES ONLY	❑	❑
47.	Have you ever had a menstrual period?	❑	❑
48.	How many periods have you had in the last 12 months?	____	

I hereby verify to the best of my knowledge that the answers which have been provided to the above questions are correct.

Signature of Student_____ Signature of Parent/Guardian _____Date _____

The student and parent/guardian consent and authorize school officials through an Athletic Health Care Trainer (AHCT), qualified coach/staff, or physician as determined by the school, to provide any first aid and/or emergency care as well as follow-up first aid or medical treatment that may be reasonably necessary for the student as determined by a school official in the course of athletic practice, competition or travel.

The student and parent/guardian further consent and authorize the school's AHCT to provide appropriate therapeutic modalities in order to return student to athletic competition, such care to be conducted under the direction of a physician.

The student and parent/guardian hereby consent to the release of medical information by physician to school to obtain information regarding the medical history, records of injury or surgery, serious illness, and rehabilitation results of the student from his/her physician(s). We understand that the purpose of this request for medical information is to assist the school in the management or rehabilitation of an injury/illness. This information is confidential and except as provided in this release will not be otherwise released by the parties in charge of the information. This release remains valid until revoked by the adult student or parent/guardian in writing.

Signature of Student_____ Signature of Parent/Guardian _____Date _____