



ST. ANNE CATHOLIC SCHOOL

STUDENT ATHLETE PHYSICAL EXAMINATION

Please print or type

Name: _____ Phone: (____) _____

Address: _____

Grade: _____ Birthdate: ____/____/____ Age: _____ Sex: ____ M ____ F

PARTS A AND B SHALL BE COMPLETED BY PARENT/GUARDIAN (NOT CHILD)

Part A: General History – check the appropriate box for each number

YES	NO		YES	NO	
☐	☐	1. Diabetes	☐	☐	11. High or low blood pressure
☐	☐	2. Seizures	☐	☐	12. Hernia
☐	☐	3. Dizziness, fainting	☐	☐	13. Sudden cardiac arrest of family member
☐	☐	4. Bleeding disorders	☐	☐	14. Absence of, or undescended testicle
☐	☐	5. Asthma, Allergies	☐	☐	15. Absence of any organ
☐	☐	6. Heart disease	☐	☐	16. Menstrual disorder
☐	☐	7. Hearing problems	☐	☐	17. Under physician care at present
☐	☐	8. Taking medication (type, reason, dosage)	☐	☐	18. Loss of consciousness or concussion
☐	☐	9. Any allergic reactions	☐	☐	19. Any health changes in the past year?
☐	☐	10. Have you ever been hospitalized?	☐	☐	20. Date of last tetanus shot: _____

Details of any YES answers _____

Part B: Orthopedic History: If the student has had, or now has, an injury to any of the following areas, give details

1. Shoulder, arm, elbow, wrist, hand, fingers, or thumb (type/when) _____
2. Hip, knee, leg, calf, ankle, foot, or toes (type/when) _____
3. Head, neck or spine (type/when) _____

Family Doctor: _____ Phone (____) _____

PARTS C, D, AND E TO BE COMPLETED BY EXAMINING PHYSICIAN

Part C: Pre-Physical

Height _____ Weight _____ Blood Pressure _____ Vision: Right _____ Left _____
DENTAL: Braces ____ Broken or missing teeth: ____ Plates ____ GLASSES: Yes ____ No ____ CONTACTS: Yes ____ No ____

Part D: General Physical

Heart _____ Lungs _____ Abdomen _____ Pupils _____ ENT _____

Part E: Orthopedic Evaluation

Spine _____ Hips/Pelvis _____ Knees _____ Ankle/Feet _____ Shoulders/Elbows _____ Wrist/Hands _____

- ☐ Approved for athletic participation
- ☐ Disapproved for athletic participation, state reason _____
- ☐ Approved for athletic participation, refer to specialist for _____
- ☐ Disapproved for athletic participation, refer to specialist for _____

Signature of physician _____

Telephone number of physician _____

Date _____

DOCTOR STAMP TO BE CLEARED HERE