CATHOLIC SCHOOL HEALTH REPORT ARCHDIOCESE OF ATLANTA

A health examination is required for all first time entrants or all new students to the school. This information is required prior the 1st day of school to be complete. For participation in sports, this physical examination is required each year to be complet after June 1, for the upcoming school year.

(Physical and completed sports packet is required before student can practice and/or play any sport)

THIS SIDE TO BE COMPLETED BY PARENT/GUARDIAN Entering Grade_____ Year_____

CHILD'S NAME: _____ SEX: M F BIRTHDATE _____
First Middle Last MM/DD/YYYY

ADDRESS: _____
Street City Zip code

MOTHER'S NAME: _____ TELEPHONE_____ _____
First Middle Last Home Work

FATHER'S NAME: _____ TELEPHONE_____ _____
First Middle Last Home Work

IN CASE OF EMERGENCY IN WHICH THE PARENTS CANNOT BE REACHED, PLEASE CALL:

	NAME	RELATIONSHIP	TELEPHONE NUMBER(S)
1)	_____	_____	_____
2)	_____	_____	_____

PLEASE LIST NAME, RELATIONSHIP AND TELEPHONE NUMBER(S) OF THOSE WHO MAY PICK THIS CHILD U FROM THIS SCHOOL: _____

Health History: (Please explain any yes answers)

a) Any known chronic illness; Asthma, Cystic Fibrosis, Diabetes, Heart, etc. Yes: _____ No: ____

b) Any known allergies; drug, environmental, food; describe: Yes: _____ No: ____

c) History of head injury, concussion, seizure, etc? Yes: _____ No: ____

d) History of any hospitalization or surgery; explain: Yes: _____ No: ____

e) Any spinal injuries or spinal defects: Yes: _____ No: ____

f) List **all** medications taken on a daily basis:

g) Note special concerns regarding participation in physical education, athletics or sports for you child:

h) Does your child wear contact lens (eyes) or have any orthodontic appliance in their mouth? Yes: _____ No: ____

*****SPECIAL EMERGENCY REFERRAL INSTRUCTIONS*****

In the event that I cannot be reached or make arrangements for emergency medical attention at the time of illness/accident, I hereby authorize:

_____ to take my child to:
Name of School

PHYSICIAN ADDRESS TELEPHONE #

HOSPITAL ADDRESS TELEPHONE #

Date of last Tetanus shot: _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

THIS SIDE TO BE COMPLETED BY PHYSICIAN **Student's Name** (PLEASE PRINT)_____

Relevant Health Information	Physical Assessment	Normal	Abnormal	Not Examined
Present Age: yrs. mos.	General Appearance			
Height (no shoes): Inches (%)	Skin			
Weight (light clothing): lbs. oz. (%)	Head			
Hemoglobin or Hematocrit (opt):	Eyes:			
Urinalysis (opt):	1) Reflex Test			
	2) Cover Test			
Other:	Ears			
Blood Pressure:	Nose, Mouth, Pharynx, Teeth			
Pulse / Respiration:	Neck(lymphatic/thyroid)			
	Heart			
	Lungs			
	Abdomen (include hernias)			
	Genitalia			
	Orthopedic			
	Neurologic			

Scoliosis Screening: Pass_____ Fail _____ Refer_____ Comments:_____

Patient Health History, Findings and Recommendations:

_____

Physical Activity: Restricted or Unrestricted (circle one) Explanation:

_____

I have examined the child named on this form, and find that he/she is able to participate in the athletic and physical education programs of the school:

Date: _____Signature: _____
(stamped signature not accepted)

Please print physician's name and address: _____
(MD / DO or PA or RNP working under the direction of a licensed physician)

Revised 7/1/05
Mandatory

Preparticipation Physical Evaluation

HISTORY FORM

Date of Exam _____

Name _____ Sex_____ Age_____ Date of birth_____

Grade_____ School_____ Sport(s)_____

Address_____ Phone_____

Personal Physician _____

In case of emergency, contact:

Name _____ Relationship_____ Phone (H)_____ Phone(W)_____

Explain "Yes" answers below.
Circle questions you don't know the answers 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 your heart race or skip beats during exercise?	☐	☐
9. Has a doctor ever told you that you have (check 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 a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:	☐	☐
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
19. Have you had a bone or joint injury that required x-rays MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes

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 allergies?	☐	☐

	Yes	No
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25. Is there anyone in your family who has asthma?	☐	☐
26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30. Have you had a herpes skin infection?	☐	☐
31. Have you ever had a head injury or concussion?	☐	☐
32. Have you been hit in the head and been confused or lost your memory?	☐	☐
33. Have you ever had a seizure?	☐	☐
34. Do you have headaches with exercise?	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39. Have you had any problems with your eyes or vision?	☐	☐
40. Do you wear glasses or contact lenses?	☐	☐
41. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42. Are you happy with your weight?	☐	☐
43. Are you trying to gain or lose 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 old were you when you had your first menstrual period? _____
49. How many periods have you had in the last 12 months?_____

Explain "Yes" answers here:_____

_____
_____
_____
_____
_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Athlete_____ Signature of Parent/Guardian_____ Date_____

©2004 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

Preparticipation Physical Evaluation

PHYSICAL EXAMINATION FORM

Name _____ Date of Birth _____

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

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

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only.
+Having a third party present is recommended for the genitourinary examination.

Notes: _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

©2004 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

Preparticipation Physical Evaluation

CLEARANCE FORM

Name_____ Sex_____ Age_____ Date of birth_____

☐ Cleared without restriction
☐ Cleared, with recommendations for further evaluation or treatment for:_____

☐ Not Cleared for ☐ All sports ☐ Certain sports: _____ Reason:_____

Recommendations:_____

EMERGENCY INFORMATION

Allergies _____

Other Information _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

© 2004 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

Preparticipation Physical Evaluation

CLEARANCE FORM

Name_____ Sex_____ Age_____ Date of birth_____

☐ Cleared without restriction
☐ Cleared, with recommendations for further evaluation or treatment for:_____

☐ Not Cleared for ☐ All sports ☐ Certain sports: _____ Reason:_____

Recommendations:_____

EMERGENCY INFORMATION

Allergies _____

Other Information _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

© 2004 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.