**THE JOHN CARROLL SCHOOL HEALTH SERVICES**

**PHYSICAL FORM 2018-2019**

***This is the student's confidential medical record only to be shared with Faculty/Staff if pertinent.***

Student Name: DOB: M / F: \_\_\_\_\_\_\_\_\_\_ Yr. of Grad: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pulse: \_\_\_\_\_\_\_\_\_\_\_\_\_

Vision: R 20/\_\_\_\_\_ L 20/\_\_\_\_\_ Corrected? Y\_\_\_\_\_ N\_\_\_\_\_ Pupils: Equal \_\_\_\_\_\_\_ Unequal\_\_\_\_\_\_\_

**MUST BE PERFORMED BY M.D., D.O., PA, or NURSE PRACTIONER**

**PHYSICALS EXPIRE ONE YEAR FROM THE DATE OF THE CARE PROVIDER’S SIGNATURE**

**PLEASE INCLUDE A PHYSICIAN SIGNED COPY OF IMMUNIZATION RECORDS**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **NORMAL** | **ABNORMAL FINDINGS** | **INITIALS** |
| **MEDICAL** |  |  |  |
| **Appearance** |  |  |  |
| **Eyes/Ears/Nose/Throat** |  |  |  |
| **Lymph Nodes** |  |  |  |
| **Heart** |  |  |  |
| **Pulses** |  |  |  |
| **Lungs** |  |  |  |
| **Abdomen** |  |  |  |
| **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** [Sport(s)]: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Reason**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Recommendation**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Physician/Nurse Practitioner/Physician’s Assistant:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Phone**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Physician/Nurse Practitioner/Physician Assistant:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby certify that I have reviewed the student pre-participation History Form and performed a comprehensive initial pre-participation physical evaluation of the herein named student within the previous 365 days of signature. On the basis of such evaluation and the review of a current History Form, I certify that the student is physically fit to participate in an interscholastic sports program for the current school year. **The date of the student pre-participation History Form and the date of the health care provider’s signature above must be after June 1st.**

|  |
| --- |
| **Physician Stamp:** |

**THE JOHN CARROLL SCHOOL HEALTH SERVICES**

**HEALTH HISTORY QUESTIONNAIRE 2018-2019 (Please complete prior to Physical Exam)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **GENERAL MEDICAL HISTORY** | Y | N | **MEDICAL QUESTIONS** | Y | N |
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? |  |  | 23. Do you cough, wheeze, or have difficulty breathing during or after exercise? |  |  |
| 2. Do you currently have an ongoing medical condition? If so, Please identify: □ Asthma □ Allergies requiring an Epi Pen □ Diabetes  □ Seizures □ Other: |  |  | 24. Do you have asthma or use asthma medicine? (inhaler, nebulizer) |  |  |
| 3. Have you ever had surgery? |  |  | 25. Were you born without or are you missing a kidney, an eye, a testicle, spleen or any other organ? |  |  |
| **HEART HEALTH ABOUT YOU** | Y | N | 26. Do you have groin pain or a painful bulge or hernia in the groin area? |  |  |
| 4. Have you ever passed out or nearly passed out DURING or AFTER exercise? |  |  | 27. Do you have any rashes, pressure sores, or other skin problems? |  |  |
| 5. Have you ever had discomfort, pain, or pressure in your chest during exercise? |  |  | 28. Have you ever had a herpes or MRSA skin infection? |  |  |
| 6. Does your heart race or skip beats during exercise? |  |  | 29. Do you have headaches with exercise? |  |  |
| 7. Has a doctor ever told you that you have (check all that apply):□ High Blood Pressure □ A heart murmur□ High cholesterol □ A heart infection □ Arrhythmia □ Other: |  |  | 30. Have you ever had a head injury or concussion? If so, date of last injury: |  |  |
| 8. Has a doctor ever ordered a test for your heart? (For ex: ECG/EKG, echocardiogram) |  |  | 31. Have you had numbness, tingling, or weakness in your arms or legs after being hit or falling? |  |  |
| 9. Do you get lightheaded or feel more short of breath than expected during exercise? |  |  | 32. Have you been unable to move your arms or legs after being hit or falling? |  |  |
| **HEART HEALTH, ABOUT YOUR FAMILY** | Y | N | 33. When exercising in heat, do you have severe muscle cramps or become ill? |  |  |
| 10. Has any family member or relative died of heart problems or had an unexpected sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? |  |  | 34. Have you had any other blood disorders? |  |  |
| 11. Does anyone in your family have a heart problem? |  |  | 35. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? |  |  |
| 12. Does anyone in your family have a pacemaker or implanted defibrillator? |  |  | 36. Do you wear glasses, contact lenses, or hearing aid? |  |  |
| 13. Does anyone in your family have Marfan syndrome,cardiomyopathy, or Long Q-T? |  |  | 37. Have you had any problems with your eyes, vision, ears, or hearing? |  |  |
| **BONE AND JOINT QUESTIONS** | Y | N | 38. Do you have an allergy to medicine, food or stinging insects that requires an Epi Pen? |  |  |
| 14. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game? |  |  | **FEMALES ONLY**39. Do you have a regular menstrual cycle? |  |  |
| 15. Have you had any broken or fractured bones or dislocated joints? |  |  | **MENTAL HEALTH** | Y | N |
| 16. 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? |  |  | 40. Are you being treated for or have you ever been treated for? If so, please identify. □ ADHD □ Depression □ Anxiety □ Eating Disorders |  |  |
| 17. Have you ever had an x-ray of your neck for atlanto-axial instability? Have you ever been told that you have that disorder or any neck/spine problem? |  |  | **PLEASE LIST ALL CURRENT MEDICATIONS**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 18. Have you ever had a stress fracture of a bone? |  |  | **EXPLAIN YES ANSWERS BELOW**#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 19. Do you regularly use a brace or assistive device? |  |  |
| 20. Do you currently have a bone, muscle, or joint injury that bothers you? |  |  |
| 21. Do any of your joints become painful, swollen, feel warm, or look red? |  |  |
| 22. Do you have a history of juvenile arthritis or connective tissue disease? |  |  |

 **PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **STUDENT SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THE JOHN CARROLL SCHOOL HEALTH SERVICES**

**consent, Release, and assumption of risk 2018-2019**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print student name) (the "Student"), is a student at The John Carroll School ("JCS").

Consent to Medical Treatment: I/We do hereby authorize JCS employees, nurses, athletic trainers, and coaches to consent to any necessary or advisable medical treatment by any licensed, certified or trained medical professional in the event of any illness or injury to the Student while in school or participating in the Athletic Program, including without limitation, any competition or practice, and while traveling to and from any competition, in the event that I/we cannot be reached after reasonable effort. In addition, if, in the judgment of any representative of JCS, the Student needs immediate care and treatment as a result of any injury or sickness sustained while in school or participating in the Athletic Program, I/we hereby request, authorize, and consent to such care and treatment as may be given to the Student by any licensed, certified or trained medical professional, athletic trainer or any other JCS representative. In either case, I/we do hereby agree to **RELEASE, HOLD HARMLESS and INDEMNIFY** JCS and its directors, officers, employees, and agents from and against any liability, claims, demands, and causes of action arising out of or related to any such treatment. I/We further agree to be fully responsible for any and all expenses incurred in connection with any such treatment, and hereby **RELEASE and DISCHARGE** JCS and its directors, officers, employees and agents from any and all responsibility and liability for such expenses.

Athletic Program: If the Student decides to participate in JCS's athletic program for the 2018-2019 school year (the "Athletic Program"). I/We understand that the Student’s participation in the Athletic Program is wholly voluntary. In consideration of the opportunity to participate in the Athletic Program, the receipt and sufficiency of which is hereby acknowledged, I/we consent to the Student's participation in the Athletic Program and agree as follows:

Consent to Disclosure of Educational Records: I/We hereby authorize JCS to release the Student's educational records to the extent the same contain medical information regarding the Student (the "Medical Records") to any health care provider in connection with the furnishing of medical treatment to the Student for any illness or injury sustained while in school or participating in the Athletic Program. I/We understand that this consent shall remain in effect until my/our written revocation is delivered to the Registrar.

Assumption of Risk, Consent and Release of Claims: I/We understand and agree that there are certain dangers, hazards and risks inherent in participating in high school athletic practice and competition, and travel associated therewith, including without limitation, death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the muscular skeletal system, and serious injury or impairment to other aspects of the above-named student's body, general health and wellbeing, the effects of any of which could last a lifetime. Because of the dangers of participating in high school athletics, I/we understand that it is the Student's responsibility to adhere to all rules and regulations of his or her sport, and that an infraction of such may result in injury to the Student and/or his or her opponent. I/We also agree not to modify any protective equipment or uniform, and understand that is the Student's responsibility to report faulty or poor-fitting equipment immediately to the coach or Certified Athletic Trainer. I/We further understand and agree that all injuries are to be promptly reported to the Certified Athletic Trainer.

I/We voluntarily and without reservation agree, for myself/ourselves, the Student, and our heirs and personal representatives, to **ASSUME ALL RISK** for any such personal injury, loss of life, or other loss and **RELEASE, HOLD HARMLESS and INDEMNIFY** JCS and its directors, officers, employees, and agents from and against any present or future liability, claims, demands, and causes of action arising out of or related to any personal injury, loss of life, or other loss sustained as a result of the Student's participation in the Athletic Program.

I/We acknowledge that I/we have carefully read, understand, and agree to be bound by the above.

**STUDENT SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_