THE JOHN CARROLL SCHOOL

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New Student and Athletic Physical Form

INSTRUCTIONS: This is the student's confidential medical record only to be shared with Faculty/Staff if pertinent. Must be performed by M.D., D.O., PA, or Nurse Practitioner. PLEASE INCLUDE A PHYSICIAN SIGNED COPY OF IMMUNIZATION RECORDS.

Student Name: _____ DOB: _____ M / F: _____ Yr. of Grad: _____

Student Height: _____ Weight: _____ BP: _____ Pulse: _____

Vision: R 20/_____ L 20/_____ Corrected? Y_____ N_____ Hearing: Pass _____ Fail_____

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
MUSCULOSKELETAL			
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:

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Health History Questionnaire Form

GENERAL MEDICAL HISTORY	Y	N
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you currently have an ongoing medical condition? If so, please identify: □ Asthma □ Allergies requiring an Epi Pen □ Diabetes □ Seizures □ Other:		
3. Have you ever had surgery?		
HEART HEALTH ABOUT YOU	**Y**	**N**
4. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
5. Have you ever had discomfort, pain, or pressure in your chest during exercise?		
6. Does your heart race or skip beats during 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:		
8. Has a doctor ever ordered a test for your heart? (For ex: ECG/EKG, echocardiogram)		
9. Do you get lightheaded or feel more short of breath than expected during exercise?		
HEART HEALTH, ABOUT YOUR FAMILY	**Y**	**N**
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)?		
11. Does anyone in your family have a heart problem?		
12. Does anyone in your family have a pacemaker or implanted defibrillator?		
13. Does anyone in your family have Marfan syndrome, cardiomyopathy, or Long Q-T?		
BONE AND JOINT QUESTIONS	**Y**	**N**
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?		
15. Have you had any broken or fractured bones or dislocated joints?		
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?		
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?		
18. Have you ever had a stress fracture of a bone?		
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?		

MEDICAL QUESTIONS	Y	N
23. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
24. Do you have asthma or use asthma medicine? (inhaler, nebulizer)		
25. Were you born without or are you missing a kidney, an eye, a testicle, spleen or any other organ?		
26. Do you have groin pain or a painful bulge or hernia in the groin area?		
27. Do you have any rashes, pressure sores, or other skin problems?		
28. Have you ever had a herpes or MRSA skin infection?		
29. Do you have headaches with exercise?		
30. Have you ever had a head injury or concussion? If so, date of last injury:		
31. Have you had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
32. Have you been unable to move your arms or legs after being hit or falling?		
33. When exercising in heat, do you have severe muscle cramps or become ill?		
34. Have you had any other blood disorders?		
35. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
36. Do you wear glasses, contact lenses, or hearing aid?		
37. Have you had any problems with your eyes, vision, ears, or hearing?		
38. Do you have an allergy to medicine, food or stinging insects that requires an Epi Pen?		
FEMALES ONLY 39. Do you have a regular menstrual cycle?		
MENTAL HEALTH	**Y**	**N**
40. Are you being treated for or have you ever been treated for? If so, please identify. □ ADHD □ Depression □ Anxiety □ Eating Disorders		
PLEASE LIST ALL CURRENT MEDICATIONS _____ _____		
EXPLAIN YES ANSWERS BELOW #_____ #_____ #_____ #_____ #_____ #_____		

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

STUDENT SIGNATURE: _____ **DATE:** _____