THE JOHN CARROLL SCHOOL

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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 Practioner. 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

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:** ____________________