

**ST. ALOYSIUS ACADEMY
ATHLETICS PHYSICAL EXAMINATION FORM 2017-2018
CONFIDENTIAL**

NAME: _____ GRADE: _____

ADDRESS: _____
Street City Zip

HOME PHONE: () _____ - _____

DATE OF BIRTH: _____

To be completed by a parent/guardian.

- | YES | NO | DOES THIS STUDENT HAVE ANY OF THE FOLLOWING: |
|-----|-----|--|
| () | () | Chronic and/or recurrent illness? _____ |
| () | () | Illness longer than one week? _____ |
| () | () | Hospitalizations? _____ |
| () | () | Surgery other than tonsillectomy? _____ |
| () | () | Missing organs? _____ |
| () | () | Take any medication? Reason? _____ |
| () | () | *Allergy to any medication? _____ |
| () | () | Problems with heart or blood pressure? _____ |
| () | () | Chest pain with exercise? _____ |
| () | () | Dizziness or fainting with exercise? _____ |
| () | () | Dizziness, fainting, frequent headaches, or seizure disorders? _____ |
| () | () | *Concussion or unconsciousness? How many times / dates? _____ |
| () | () | Heat exhaustion or heat stroke? _____ |
| () | () | Abnormal bleeding or bruising? _____ |
| () | () | Allergies? _____ |
| () | () | *Allergic to bee stings? Prescribed Benadryl and/or EpiPen (circle one/both). _____ |
| () | () | Asthma? _____ |
| () | () | Wear eyeglasses and/or contact lenses (circle one/both). _____ |
| () | () | Wear dental bridges, braces, plates (circle one). _____ |
| () | () | Experience severe muscle cramps or become ill when exercising in the heat? _____ |
| () | () | Has he or a family member been diagnosed with Sickle Cell Trait or Sickle Cell Disease?
_____ |

To be completed by a parent/guardian.

- | YES | NO | IS THERE ANY HISTORY OF THE FOLLOWING: |
|-----|-----|---|
| () | () | Injuries requiring medical treatment? _____ |
| () | () | Neck injuries? (Date) R / L _____ |
| () | () | Low Back? (Date) R / L _____ |
| () | () | Knee injuries? (Date) R / L _____ |
| () | () | Ankle injuries? (Date) R / L _____ |
| YES | NO | IS THERE ANY HISTORY OF THE FOLLOWING: |
| () | () | Shoulder injuries? (Date) R / L _____ |
| () | () | Elbow injuries? (Date) R / L _____ |
| () | () | Wrist injuries? (Date) R / L _____ |
| () | () | Other joint injuries? (Date) R / L _____ |

- () () Broken bones? (Date) R / L _____
 () () Is there any reason this student should not participate in athletics or PE? _____
 () () Has any family member under the age of 50 died suddenly of causes other than an accident?

 () () Hepatitis? _____
 () () Undescended testicle? _____
 () () *Diabetes? _____
 () () Hearing impairment? _____

Please use this space to explain additional information to any YES answers: _____

Parent/Guardian Signature _____

Date _____

PHYSICIAN INFORMATION

To be completed by a physician.

	Normal	Abnormal	Not Examined
1. Eyes	()	()	()
2. Ears, Nose, Throat	()	()	()
3. Mouth and Teeth	()	()	()
4. Neck (soft tissue)	()	()	()
5. Cardiovascular	()	()	()
6. Chest and Lung	()	()	()
7. Abdomen	()	()	()
8. Genitalia – Hernia	()	()	()
9. Sexual Maturity	()	()	()
10. Skin and Lymphatic	()	()	()
11. Neck	()	()	()
12. Spine	()	()	()

Scoliosis Screening - State Mandate for Grade 6 and Grade 7

13. Shoulders	()	()	()
14. Arms and Hands	()	()	()
15. Hips	()	()	()
16. Thighs	()	()	()
17. Knees	()	()	()
18. Ankles	()	()	()
19. Feet	()	()	()
20. Neurological	()	()	()

_____ HEIGHT: _____ WEIGHT: _____ BMI: _____

PULSE: _____ / MIN. BLOOD PRESSURE: _____ / _____ YEAR OF LAST TETANUS: _____

NOTE: A physician's signature is required for approval to participate in St. Aloysius Academy Athletic programs.

Name of Physician _____

Signature of Physician: _____ Date of exam: _____