

ST. JOSEPH SCHOOL ATHLETIC SCREENING PHYSICAL

Name _____ Date _____

Date of Birth _____ Age _____ Grade _____

PRE-PARTICIPATION EVALUATION - HISTORY

To be completed by parent/guardian
(If yes, explain)

YES

NO

1. Have any members of your family under age 50 had a heart attack or heart problems? _____

2. Has your child ever been told he/she has a heart murmur, high blood pressure, extra heart beats, or a heart abnormality? _____

3. Does your child have to stop while running around a track twice (1/4 mile)? _____

4. Is your child regularly taking any medication? _____

Name of medication _____ Dose _____

5. Has your child ever passed out or been knocked out, had a concussion or experienced seizures of any type? Describe. _____

6. Please describe briefly any illness, condition or injury affecting your child that:

a. Required him/her to be treated by a physician or go to the hospital either as a patient overnight or in the emergency room or for x-rays? _____

b. Required an operation? _____

c. Lasted longer than a week? _____

d. Caused him/her to miss a game or practice? _____

e. Is related to allergies (hayfever, hives, asthma or medicine)? _____

7. Fractures or joint problems; explain: _____

PARENT AUTHORIZATION

I hereby give my permission for the doctors to examine my son/daughter for participation in school sports. I also hereby give my consent for the above St. Joseph student to engage in physical education, intramural and interscholastic athletics at St. Joseph School. I also give my consent for the student to participate and accompany the team on out of town trips.

Signature of Parent

Date

FOR PHYSICIAN'S USE ONLY

PARTICIPATION EVALUATION - Physical

Check if Satisfactory

- 1. Blood Pressure (sitting) _____/_____
- 2. Vision: L 20/_____ R. 20/_____
- 3. Height _____ 4. Weight _____
- 5. Skin _____
- 6. Chest: Pulse/Rhythm/Murmurs/Lungs _____

- 7. Hernia: _____
- 8. Orthopedic Status: _____

I hereby certify that this student was examined and is physically able to compete in supervised athletics.

- Disposition: _____ No Participation
 _____ Limited Participation
 _____ Full Participation
 _____ Referral to Personal Physician

Recommendations: _____

 Signature of Reviewing Physician

 Date