

# St. Pius X Middle School Medical History and Physical Examination 2008 - 2009

Name \_\_\_\_\_ Grade \_\_\_\_\_ Sex \_\_\_\_\_ Date Of Birth \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Parent's Names \_\_\_\_\_

Parent's Business Phone \_\_\_\_\_ Parent's Cell Phone \_\_\_\_\_

If Parents Can Not Be Reached Please Call \_\_\_\_\_

Personal Physician \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Co \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Phone \_\_\_\_\_

School Attending \_\_\_\_\_

**Explain "Yes" answers below.  
Circle questions you don't know the answers to.**

**Yes No**

**Yes No**

1. Has a doctor ever denied or restricted your participation in sports for any reason?  Yes  No
2. Do you have an ongoing medical condition (like diabetes or asthma)?  Yes  No
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?  Yes  No
4. Do you have allergies to medicines, pollens, foods, or stinging insects?  Yes  No
5. Have you ever passed out or nearly passed out DURING exercise?  Yes  No
6. Have you ever passed out or nearly passed out AFTER exercise?  Yes  No
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?  Yes  No
8. Does your heart race or skip beats during exercise?  Yes  No
9. Has a doctor ever told you that you have (check all that apply):
 

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> A heart murmur
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> A heart infection
10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)  Yes  No
11. Has anyone in your family died for no apparent reason?  Yes  No
12. Does anyone in your family have a heart problem?  Yes  No
13. Has any family member or relative died of heart problems or of sudden death before age 50?  Yes  No
14. Does anyone in your family have Marfan syndrome?  Yes  No
15. Have you ever spent the night in a hospital?  Yes  No
16. Have you ever had surgery?  Yes  No

17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:  Yes  No
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:  Yes  No
19. 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? If yes, circle below:  Yes  No

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes

20. Have you ever had a stress fracture?  Yes  No
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?  Yes  No
22. Do you regularly use a brace or assistive device?  Yes  No
23. Has a doctor ever told you that you have asthma or allergies?  Yes  No

24. Do you cough, wheeze, or have difficulty breathing during or after exercise?  Yes  No
25. Is there anyone in your family who has asthma?  Yes  No
26. Have you ever used an inhaler or taken asthma medicine?  Yes  No
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?  Yes  No
28. Have you had infectious mononucleosis (mono) within the last month?  Yes  No
29. Do you have any rashes, pressure sores, or other skin problems?  Yes  No
30. Have you had a herpes skin infection?  Yes  No
31. Have you ever had a head injury or concussion?  Yes  No
32. Have you been hit in the head and been confused or lost your memory?  Yes  No
33. Have you ever had a seizure?  Yes  No
34. Do you have headaches with exercise?  Yes  No
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?  Yes  No
36. Have you ever been unable to move your arms or legs after being hit or falling?  Yes  No
37. When exercising in the heat, do you have severe muscle cramps or become ill?  Yes  No
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?  Yes  No
39. Have you had any problems with your eyes or vision?  Yes  No
40. Do you wear glasses or contact lenses?  Yes  No
41. Do you wear protective eyewear, such as goggles or a face shield?  Yes  No
42. Are you happy with your weight?  Yes  No
43. Are you trying to gain or lose weight?  Yes  No
44. Has anyone recommended you change your weight or eating habits?  Yes  No
45. Do you limit or carefully control what you eat?  Yes  No
46. Do you have any concerns that you would like to discuss with a doctor?  Yes  No

**FEMALES ONLY**

47. Have you ever had a menstrual period?  Yes  No
48. How old were you when you had your first menstrual period? \_\_\_\_\_
49. How many periods have you had in the last 12 months? \_\_\_\_\_

**Explain "Yes" answers here:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

Signature of Athlete \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

# Preparticipation Physical Evaluation

## PHYSICAL EXAMINATION FORM

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body Fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_ / \_\_\_\_ (\_\_\_\_ / \_\_\_\_, \_\_\_\_ / \_\_\_\_)

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

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

\*Multiple-examiner set-up only.  
 +Having a third party present is recommended for the genitourinary examination.

Notes: \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

**Preparticipation Physical Evaluation**

**CLEARANCE FORM**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

- Cleared without restriction
- Cleared, with recommendations for further evaluation or treatment for: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Not Cleared for  All sports  Certain sports: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_  
 \_\_\_\_\_

**EMERGENCY INFORMATION**

Allergies \_\_\_\_\_

Other Information \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

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**PARENTAL CONSENT**

I HEREBY GIVE MY CONSENT FOR THE ABOVE NAMED STUDENT TO REPRESENT St. Pius X High School in athletic activities. I also give my consent for my student to accompany any school team of which he/she is a member on any of its local or out-of-town trips. I fully understand that the school will provide transportation when it is possible. If this is not possible, he/she may only transport themselves or be transported by an authorized adult. I authorize the school to obtain, through a physician of its own choice, any emergency medical care that may become reasonably necessary for the student in the course of such athletic activities or such travel. I also agree not to hold the school responsible for any injury occurring to the above named student in the course of such athletic activities or such travel.

\_\_\_\_\_  
 SIGNATURE OF PARENT OR GUARDIAN \_\_\_\_\_

DATE \_\_\_\_\_

\_\_\_\_\_  
 Please attach Georgia Certificate of Immunization Form 3231 (New Students Only)