

Name _____ Grade 9 10 11 12 Date of Birth _____ Sex M F
 Address _____ City/Zip _____ Phone _____
 Emergency Contact _____ Relationship _____
 Home Phone _____ Work Phone _____ Mobile Phone _____
 Personal Physician _____ Phone _____
 Address _____ City _____ Zip Code _____
 Hospital preference (in case of emergency) _____
 Insurance Company _____ Group/Policy # _____ Type (circle one) HMO PPO
 Intended Sport(s) _____

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

<p>1. Has a doctor ever denied or restricted your participation in sports for any reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Do you have an ongoing medical condition (like diabetes or asthma)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you have allergies to medicines, pollens, foods, or stinging insects? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have you ever passed out or nearly passed out DURING exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you ever passed out or nearly passed out AFTER exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you ever had discomfort, pain, or pressure in your chest during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Does your heart race or skip beats during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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</p> <p>10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Has anyone in your family died for no apparent reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Does anyone in your family have a heart problem? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Has any family member or relative died of heart problems or of sudden death before age 50? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Does anyone in your family have Marfan syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Have you ever spent the night in a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <table border="1" style="width: 100%; text-align: center; border-collapse: collapse;"> <tr> <td>Head</td><td>Neck</td><td>Shoulder</td><td>Upper Arm</td><td>Elbow</td><td>Forearm</td><td>Hand/Fingers</td><td>Chest</td> </tr> <tr> <td>Upper Back</td><td>Lower Back</td><td>Hip</td><td>Thigh</td><td>Knee</td><td>Calf/Shin</td><td>Ankle</td><td>Foot/Toes</td> </tr> </table> <p>20. Have you ever had a stress fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. Do you regularly use a brace or assistive device? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>23. Has a doctor ever told you that you have asthma or allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/Fingers	Chest	Upper Back	Lower Back	Hip	Thigh	Knee	Calf/Shin	Ankle	Foot/Toes	<p>24. Do you cough, wheeze, or have difficulty breathing during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>25. Is there anyone in your family who has asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>26. Have you ever used an inhaler or taken asthma medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>28. Have you had infectious mononucleosis (mono) within the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>29. Do you have any rashes, pressure sores, or other skin problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>30. Have you had a herpes skin infection? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>31. Have you ever had a head injury or concussion? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>32. Have you been hit in the head and been confused or lost your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>33. Have you ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>34. Do you have headaches with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>36. Have you ever been unable to move your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>37. When exercising in the heat, do you have severe muscle cramps or become ill? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>39. Have you had any problems with your eyes or vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>40. Do you wear glasses or contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>41. Do you wear protective eyewear, such as goggles or a face shield? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>42. Are you happy with your weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>43. Are you trying to gain or lose weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>44. Has anyone recommended you change your weight or eating habits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>45. Do you limit or carefully control what you eat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>46. Do you have any concerns that you would like to discuss with a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>FEMALES ONLY</p> <p>47. Have you ever had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>48. How old were you when you had your first menstrual period? _____</p> <p>49. How many periods have you had in the last 12 months? _____</p> <p>Explain "Yes" answers here: _____ _____ _____ _____ _____</p>
Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/Fingers	Chest										
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/Shin	Ankle	Foot/Toes										

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 _____

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I, the undersigned parent of the above-named student, a minor and student at Archbishop Mitty High School, hereby authorize any supervisor employed by Archbishop Mitty High School to consent to any examination, treatment, emergency surgery, anesthetic, and/or hospital care which is deemed advisable by any physician licensed under the provisions of the Medical Practice Act. This consent is given pursuant to the provision of section 25.8 Civil Code of California, and shall be effective for one year from the signature date listed below. I also understand that this examination is primarily for sports participation and is not intended to replace the routine health care visits as recommended by the student's personal physician.

➔ **Parent Signature** _____ **Date:** _____

STUDENT NAME:

GRADE:

ARCHBISHOP MITTY HIGH SCHOOL DEPARTMENT OF ATHLETICS

PHYSICAL EXAMINATION

(To be completed by a Medical Professional)

Height: _____	Weight: _____	Pulse: _____	Blood Pressure: _____/_____
Visual Acuity: R 20/ _____ L 20/ _____		Pupils: Equal / Unequal (R > L or L > R)	
Corrected: Y / N			

MUSCULOSKELETAL EXAM		NORMAL	ABNORMAL FINDINGS	INITIALS
Neck	Rom			
	Strength			
	Joint Stability			
Shoulders	Rom			
	Strength			
	Joint Stability			
Elbows	Rom			
	Strength			
	Joint Stability			
Forearms/Wrists	Rom			
	Strength			
	Joint Stability			
Hands/Fingers	Rom			
	Strength			
	Joint Stability			
Back	Rom			
	Strength			
	Joint Stability			
Hips/ Thighs	Rom			
	Strength			
	Joint Stability			
Knees	Rom			
	Strength			
	Joint Stability			
Lower Leg/Ankles	Rom			
	Strength			
	Joint Stability			
Feet/ Toes	Appearance			

MEDICAL SCREEN		NORMAL	ABNORMAL FINDINGS
Appearance			
Eyes, Ears, Nose, Throat			
Lungs			
Heart – Rhythm: Regular	Irregular		
Murmur: No	Yes		
Abdomen			
Skin			

ATHLETIC CLEARANCE:

- Cleared without restrictions
- Cleared with recommendations for further evaluation/treatment for: _____
- Participation limited to specific sport (**See comments below)
- No athletic participation (**See comments below)

** Comments/ Recommendations: _____

<p>I hereby certify that I have, on this date, examined this student and that on the basis of this examination and the student's medical history as furnished to me, found no reason which would make it medically inadvisable for this student to compete in athletics, except for those indicated above.</p> <p>Physician's Name (Print): _____</p> <p>Physician's Signature: _____ Date: _____</p>	<p>Use space provided below for medical office address</p>
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