



PHYSICAL, HEALTH HISTORY & CONSENT SAINT MARY'S HIGH SCHOOL 2010-2011

ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(The Parent or Guardian should fill out this form with assistance from the student athlete.)

Name _____ Sex _____ Age _____ Date of Birth _____ Grade _____

Address _____ Phone _____

In case of emergency, contact: Name: _____

Explain "Yes" answers below. Phone (H): _____ (W) _____
Circle questions you don't know the answer to. Cell Phone: _____

| | Yes | No | | Yes | No | | | | | | | | | | | | | | | | | | |
|---|----------------------------------|------------------------------------|--|--------------------------|--------------------------|-------------------------------|--------------------------------|------------------------------|-------------------------------|----------------------------------|--------------------------------|-------------------------------|--------------------------------|-------------------------------|--------------------------------|-------------------------------|------------------------------------|-----------------------------------|---------------------------------|--------------------------------|------------------------------------|--|-------------------------------|
| 1. Have you had a medical illness or injury since your last check-up or sports physical? Do you have an ongoing or chronic illness? Are you currently being treated for an injury or condition? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you cough, wheeze, or have trouble breathing during or after activity? Do you have asthma? Do you use an inhaler? Do you have seasonal allergies that require medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | |
| 2. Have you ever been hospitalized overnight? Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you had any problems with your eyes or vision? Do you wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | |
| 4. Do you have any allergies to medications? Do you have any allergies to pollen, food or stinging insects? Have you ever had a rash or hives develop during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever had a sprain, strain, or swelling after injury? Have you broken or fractured any bones or dislocated any joints? Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | |
| 5. Have you ever passed out during or after exercise? Have you ever been dizzy during or after exercise? Have you ever had chest pain during or after exercise? Do you get tired more quickly than your friends during exercise? Have you ever had racing of your heart or skipped heartbeats? Have you had high blood pressure or high cholesterol? Have you ever been told you have a heart murmur? Have you had a severe viral infection (i.e., mononucleosis or myocarditis) within the last month? Has a doctor ever denied or restricted your participation in sports for any heart problems? Has anyone in your immediate family had the following conditions? Diabetes <input type="checkbox"/> Heart disease <input type="checkbox"/> other <input type="checkbox"/> Sudden death prior to age 50 <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <p><i>If yes, check appropriate box below.</i></p> <table border="0"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/> Hip</td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Forearm</td> <td><input type="checkbox"/> Thigh</td> </tr> <tr> <td><input type="checkbox"/> Back</td> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/> Knee</td> </tr> <tr> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/> Shin/calf</td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/> Finger</td> <td><input type="checkbox"/> Ankle</td> </tr> <tr> <td><input type="checkbox"/> Upper arm</td> <td></td> <td><input type="checkbox"/> Foot</td> </tr> </table> | | | <input type="checkbox"/> Head | <input type="checkbox"/> Elbow | <input type="checkbox"/> Hip | <input type="checkbox"/> Neck | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh | <input type="checkbox"/> Back | <input type="checkbox"/> Wrist | <input type="checkbox"/> Knee | <input type="checkbox"/> Chest | <input type="checkbox"/> Hand | <input type="checkbox"/> Shin/calf | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Finger | <input type="checkbox"/> Ankle | <input type="checkbox"/> Upper arm | | <input type="checkbox"/> Foot |
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| <input type="checkbox"/> Back | <input type="checkbox"/> Wrist | <input type="checkbox"/> Knee | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Hand | <input type="checkbox"/> Shin/calf | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Finger | <input type="checkbox"/> Ankle | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Upper arm | | <input type="checkbox"/> Foot | | | | | | | | | | | | | | | | | | | | | |
| 6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Do you want to weigh more or less than you do now? Do you lose weight regularly to meet weight requirements for your sport? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | |
| 7. Have you ever had a head injury or concussion? Have you ever been knocked out, become unconscious, or lost your memory? Have you ever had a seizure? Do you have frequent or severe headaches? Have you ever had numbness or tingling in your arms, hands, legs, or feet? Have you ever had a stinger, burner, or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you feel stressed? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | |
| 8. Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Do you or have you ever used: Smokeless tobacco <input type="checkbox"/> Cigarettes <input type="checkbox"/> Alcohol <input type="checkbox"/> Recreational drugs <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | |

Explanation: _____

PARENTAL PERMISSION:
I/We give our permission for _____ to participate in organized interscholastic athletics, realizing that such activity involves the potential for injury which is inherent in all sports. I/We acknowledge that even with the best coaching, use of the most advanced protective equipment and strict observance of rules, injuries are still a possibility. On rare occasions, these injuries can be so severe as to result in total disability, paralysis, quadriplegia, or even death.
I/We acknowledge that I/We have read and understand this warning.

CONSENT FOR EMERGENCY CARE:
Be It Known that I, the undersigned parent or guardian of the student above-named, do hereby give and grant unto any medical doctor or hospital my consent and authorization to render such aid, treatment or care to said student as, in the judgment of said doctor or hospital, may be required, on an emergency basis, in the event said student should be injured or stricken ill while participating in an Interscholastic activity sponsored or sanctioned by Arizona Interscholastic Association, Inc., of which the above named school a member.
IT IS HEREBY understood that the consent and authorization hereby given and granted are continuing, and are intended throughout the current school year.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.
I understand and acknowledge that truthful and accurate information is essential in properly determining whether the student should be cleared for athletic participation.
I hereby consent for the student named above, to be given medical care by the doctor selected by the school.

Signature of Parent/Guardian _____ Signature of Student Athlete _____ Date _____

**Saint Mary's High School -2010-11
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 _____

SPORTS PARTICIPATION: Fall Season 1. _____ Winter Season 2. _____ Spring Season 3. _____
 (Example: football, basketball, track & field)

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

CLEARANCE FORM

- 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