Duchesne Academy of the Sacred Heart

2016-2017

Student's Name_____ Nick Name (if any) _____

Date of Birth_____ Age_____ Grade for 2016-2017_____

Physical Examination/Pre-participation Physical Evaluation:

Height: _____ Weight: _____ Pulse: _____ BP :_____/_____(_____/_____,_____/_____)

Vision: R 20/_____ L 20/_____ Corrected: ❑Yes ❑No Pupils: ❑Equal ❑Unequal

Hearing: R_____ L_____ Pass Fail Refer Spinal Screen: Type of Test_____ Results_____ Referral_____

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart – Auscultation of the heart in supine position			
Heart – Auscultation of the heart in standing position			
Heart – lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			

MUSCULOSKELETAL

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Comments Regarding Abnormal Findings: _____

Participation Recommendations:
- ❑ Cleared
- ❑ Cleared after evaluation/rehabilitation for: _____
- ❑ NOT CLEARED for: _____ Reason: _____

Recommendations: _____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, or a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners. Examination forms signed by any other health care practitioner, including chiropractic exams will not be accepted.

Name of Physician (print/type):_____ Date of Exam: _____

Physician Address/Phone: _____

Physician's Signature: _____

2016-2017

Duchesne Academy of the Sacred Heart

PRE-PARTICIPATION PHYSICAL EVALUATION – MEDICAL HISTORY

Revised 03/10/2016

This MEDICAL HISTORY FORM must be completed ***annually*** by guardian and student in order for the student to participate in athletic events. These questions are designed to determine if the student has developed any condition which would put the athlete at risk during an athletic event. **THIS FORM MUST BE ON FILE PRIOR TO ANY ATHLETIC PARTICIPATION.**

Student's Name _____ Sex ____ Age _____ DOB_____/_____/_____ Hm Phone _____-_____-_____

Address _____ City_____ Zip _____

Grade 2015-2016 _____ Personal Physician _____Physician's Office Phone _____-_____-_____

*Explain "Yes" answers in the box below**. Circle questions you are unsure of. Any YES answers to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, or nurse practitioner is required before any participation in athletic events.*

		Yes	No
1.	Have you had a medical illness or injury since your last checkup or sports physical?	☐	☐
2.	Have you been hospitalized overnight in the past year?	☐	☐
	Have you ever had surgery?	☐	☐
3.	Have you ever passed out 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 skilled heartbeats?	☐	☐
	Have you had high blood pressure or high cholesterol?	☐	☐
	Have you ever been told you have a heart murmur?	☐	☐
	Has any family member or relative died of heart problems or sudden death before the age of 50?	☐	☐
	Has any family member been diagnosed with enlarged heart, dilated cardiomyopathy, long QT syndrome or other abnormal heart conditions?	☐	☐
	Have you had a severe vital infection (ex: myocarditis or mononucleosis) within the last month?	☐	☐
	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
4.	Have you ever had a head injury or concussion?	☐	☐
	Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
	If yes, how many times? ____		
	When was the last concussion: _____		
	How severe was each? (Explain below)		
	Have you ever had a seizure?	☐	☐
	Do you have frequent 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?	☐	☐
5.	Have you ever been dizzy during or after exercise?	☐	☐
6.	Have you ever become ill from exercising in the heat?	☐	☐
7.	Do you have any problems with your eyes or vision?	☐	☐
8.	Are you missing any paired organs?	☐	☐
9.	Are you under a doctor's case?	☐	☐
10.	Are you currently taking any prescription or non-prescription (OTC) medication, pills, or using an inhaler?	☐	☐
11.	Do you have any allergies (ex: to medicine, food, or insects)?	☐	☐
12.	Do you have any current skin problems (ex: rashes, fungus, blisters)?	☐	☐
13.	Do you use any special protective or corrective equipment or devices that aren't usually worn for your sport?	☐	☐

		Yes	No
14.	Have you ever become unexpectedly short of breath with exercise?	☐	☐
	Do you have asthma?	☐	☐
	Do you have seasonal allergies that require medical treatment?	☐	☐
15.	Do you use any special protective or corrective equipment or devices that aren't usually worn for your sport?	☐	☐
16.	Have you ever had a sprain, strain, or swelling after an injury?	☐	☐
	Have you ever broken or fractured any bones or dislocated any joints?	☐	☐
	Have you had any other problems with pain or swelling in muscles, tendons, or joints?	☐	☐
	If yes, check appropriate box and explain below:		

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/Calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper Arm		☐ Foot

17.	Do you want to weigh more or less than you do now?	☐	☐
	Do you lose weight to meet weight requirements for your sport?	☐	☐
18.	Do you feel stressed out?	☐	☐
19.	Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	☐	☐

FEMALES ONLY

20. When was your first menstrual period? _____
    When was your most recent menstrual period? _____
    How much time do you usually have from the start of one period to the start of another? _____
    How many periods have you had in the last year? _____
    What was the longest between periods in the last year? _____

An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (#3), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, or nurse practitioner.

**EXPLAIN "YES" ANSWERS IN BOX BELOW (attach sheet if necessary)

_____
_____
_____

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of injury or sickness, I do hereby consent to such care and treatment be given by any physician, athletic trainer, nurse or school representative.

If, between this date and the beginning of athletic competition, any illness or injury should occur, I agree to notify the school authorities of such illness or injury.

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

Student Signature: _____ Guardian Signature: _____ Date: _____

For School Use Only:

This Medical History Form was reviewed by: Printed Name: _____ Date: _____ Signature:_____