

Holy Spirit Episcopal School

ATHLETICS PARTICIPATION PHYSICAL EVALUATION—MEDICAL HISTORY

This form must be completed annually by parent (or guardian) and student, and returned to the Athletic Director prior to Middle School athletic participation.

Student's Name _____ Grade _____
 Mother's Name _____ Phone: (H) _____ (W) _____ (Cell) _____
 Father's Name _____ Phone: (H) _____ (W) _____ (Cell) _____
 Family Physician's Name _____ Phone: _____

In case of emergency and parents are unavailable, contact:

Name _____ Relationship _____ Phone (H) _____ (W) _____ (Cell) _____

Explain all "Yes" answers below. Circle questions to which you do not know the answer.

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	10. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized overnight or had surgery in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	11. Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or over-the-counter medication or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	12. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (e.g., knee brace, retainer, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies (e.g., pollen, medicine, food, stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, check appropriate box and explain below.		
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip		
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh		
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee		
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Shin/Calf		
Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Ankle		
Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long AT syndrome, Marfan's syndrome, or abnormal heart rhythm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper Arm <input type="checkbox"/> Foot		
Have you had a severe viral infection (e.g., myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	15. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any current skin problems (e.g., itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	16. Record the dates of your most recent immunizations (shots) for: Tetanus _____ Measles _____		
7. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B _____ Chickenpox _____		
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 one? _____	<input type="checkbox"/>	<input type="checkbox"/>	17. Are you under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	Females Only:		
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	When was your first menstrual period? _____		
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>	When was your most recent menstrual period? _____		
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	How much time do you usually have from the start of one period to the start of another? _____		
8. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	How many periods have you had in the last year? _____		
9. Have you ever gotten unexpectedly short of breath with exercise?	<input type="checkbox"/>	<input type="checkbox"/>	What was the longest time between periods in the last year? _____		
Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>	Explain "Yes" answers here:		
Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	_____		

It is understood that even though protective equipment is worn by the athlete whenever needed, the possibility of an accident still exists. Neither the Greater Houston Athletic Conference nor Holy Spirit Episcopal School assumes any responsibility if an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, nurse, or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If any illness or injury that may limit this student's participation should occur between this date and the beginning of athletic practice and competition, I agree to notify the Athletic Director of such illness or injury.

To the Parent: Please check all sports in which this student is allowed to participate.

- Volleyball (Girls) Soccer (Girls & Boys) Basketball (Girls & Boys) Track (Girls & Boys) Softball (Girls) Baseball (Boys)

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

Student Signature: _____ Parent/Guardian Signature: _____ Date: _____

(See Other Side)

ATHLETICS PARTICIPATION PHYSICAL EVALUATION—PHYSICAL EXAMINATION

This Physical Examination Form must be completed annually and returned to the Athletic Director prior to Middle School athletic participation.

Student's Name _____ Sex _____ Age _____ Date of Birth _____
 Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ Blood Pressure ____/____ (____/____, ____/____)
 Vision R 20/____ L 20/____ Corrected: Y N Pupils: Equal ____ Unequal ____

	NORMAL	ABNORMAL FINDINGS
MEDICAL		
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart—Auscultation of the heart in the standing position		
Heart—Lower extremity pulses		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

CLEARANCE

- Cleared for participation in athletics
- Cleared after completing 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 chiropractors, will not be accepted.

Name (print/type) _____ Date of Examination: _____
 Address: _____
 Phone Number: _____ Signature: _____

(See Other Side)