

Please make a copy of this completed form for your records.

St. John Bosco High School

PHYSICAL - MEDICAL - AUTHORIZATION FOR TREATMENT

(Please type or print)

Student's Name: _____ Birth Date: _____ Sex: Male Grade: _____ ID# _____
Last First Middle

School: St. John Bosco High School 13640 Bellflower Blvd., Bellflower, CA 90706 Tel: 562.920.1734 Place of Birth _____

Student's Address _____
Street City Zip Telephone

Parent(s) or Guardian(s) Name _____

Address (if different than student) _____
Street City Zip Telephone

Family Physician's Name, Address, Telephone _____

History

This section is to be carefully completed by the student and his parent(s) or legal guardian(s) before entering ST. JOHN BOSCO HIGH SCHOOL in order to help detect possible risks.

Explain "YES" answers below. Circle questions you don't know the answer to.

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|---|------------------------------------|------------------------------------|
| 1. Have you had a medical illness or injury since your last checkup or sports physical? | <input type="checkbox"/> | <input type="checkbox"/> | 31. Do you cough, wheeze or have trouble breathing during or after activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an ongoing or chronic illness? | <input type="checkbox"/> | <input type="checkbox"/> | 32. Do you have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been hospitalized overnight? | <input type="checkbox"/> | <input type="checkbox"/> | 33. Do you have seasonal allergies that require medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 34. 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"/> |
| 5. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> | 35. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. 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"/> | 36. Do you wear glasses, contacts or protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you think you are in good health? | <input type="checkbox"/> | <input type="checkbox"/> | 37. Have you ever had a sprain, strain or swelling after injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insect)? | <input type="checkbox"/> | <input type="checkbox"/> | 38. Have you broken or fractured any bones or dislocated any joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)? | <input type="checkbox"/> | <input type="checkbox"/> | 39. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever had a rash or hives develop during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | <i>If yes, check the appropriate box and explain below.</i> | | |
| 11. Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Head | <input type="checkbox"/> Upper Arm | <input type="checkbox"/> Hand |
| 12. Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Neck | <input type="checkbox"/> Elbow | <input type="checkbox"/> Finger |
| 13. Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Back | <input type="checkbox"/> Forearm | <input type="checkbox"/> Hip |
| 14. Do you get tired more quickly than your friends do during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Chest | <input type="checkbox"/> Wrist | <input type="checkbox"/> Thigh |
| 15. Have you ever had racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Shoulder | | <input type="checkbox"/> Knee |
| 16. Have you had high blood pressure or high cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> | | | <input type="checkbox"/> Shin/calf |
| 17. Have you ever been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> | | | <input type="checkbox"/> Ankle |
| 18. Has any family member or relative died of heart problems or of sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | | | <input type="checkbox"/> Foot |
| 19. Is there a family history of heart problems in a close relative younger than age 50 (examples are enlarged heart, cardiomyopathy, long QT interval, abnormal EKG, abnormal heart rhythm)? | <input type="checkbox"/> | <input type="checkbox"/> | 40. Do you want to weigh more or less than you do now? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you had a severe heart infection (for example, myocarditis or pericarditis)? | <input type="checkbox"/> | <input type="checkbox"/> | 41. Do you lose weight regularly to meet weight requirements for your sport? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Is there a family history of Marfan's Syndrome? | <input type="checkbox"/> | <input type="checkbox"/> | 42. Do you feel stressed out? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Has a physician ever denied or restricted your participation in sports for any heart problem? | <input type="checkbox"/> | <input type="checkbox"/> | 43. Record the dates of your most recent immunizations (shots) for: | | |
| 23. Have you ever had a severe viral infection within the last month (for example, mononucleosis)? | <input type="checkbox"/> | <input type="checkbox"/> | Tetanus _____ | Measles _____ | |
| 24. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B _____ | Chickenpox _____ | |
| 25. Have you ever been knocked out, become unconscious or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> | DATES & DEADLINES | | |
| 26. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> | Physicals must take place annually during the summer. Athletes must have their physicals completed prior to the start of summer practice. | | |
| 27. Do you have frequent or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> | ALL PARTICIPANTS | | |
| 28. Have you ever had numbness or tingling in your arms, hands, legs or feet? | <input type="checkbox"/> | <input type="checkbox"/> | Explain "Yes" answers here: (add attachments if necessary) | | |
| 29. Have you ever had a stinger, burner or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| 30. Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| | | | _____ | | |
| | | | _____ | | |

We consent to the participation of the above-named student in the interscholastic program of his school including practice sessions and travel to and from athletic contests. We also agree to emergency medical treatment as deemed necessary by designated school authorities.

Student Signature _____ Parent or Guardian Signature _____ Date _____
The student has family insurance ___ Yes ___ No; If yes, family insurance co. name, policy #: _____

NOTE: History and Consent Must be Completed Prior to Physical Examination

Modified from the form approved by the American Academy of Family Physicians, the American Academy of Pediatrics, the American Medical Society for Sports Medicine, the American Orthopaedic Society for Sports Medicine and the American Osteopathic Academy of Sports Medicine.

Due Date for all fall athletes (cross country, football, and water polo) -the day before your first practice.
Final Due Date for the remaining student body (ALL STUDENTS) -the first day of school.

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St. John Bosco High School

PHYSICAL EXAMINATION (MUST BE COMPLETED BY DOCTOR)

(Please type or print)

Student's Name _____ Birth Date _____
Last First Middle

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP ____/____

Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal ____ Unequal ____

Normal

Abnormal Findings

Initials*

MEDICAL

Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

MUSCULOSKELETAL

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

Clearance

Cleared

Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____

PHYSICIAN PLEASE PRINT NAME AND SIGN

I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to participate in supervised athletic activities (Note exceptions above).

Physician's Name and Address (stamp or print)
(Physician must be an Medical Doctor)

Physician's Signature

Date

Physician's Telephone Number

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