

DIOCESE OF CHARLOTTE

Medical Examination Form for Sports Registration

Physical Examination

Date of Exam: _____

Name: _____ Age: _____ Date of Birth: _____

Height: _____ Weight: _____ BP: _____ Pulse: _____

Vision: R 20/ _____ L 20/ _____ Corrected: Y _____ N _____ Pupils: _____

| | NORMAL | ABNORMAL FINDINGS | INITIALS |
|------------------------|--------|-------------------|----------|
| GENERAL | | | |
| PULSES | | | |
| HEART | | | |
| LUNGS | | | |
| ENT | | | |
| SKIN/SCALP | | | |
| ABDOMEN | | | |
| GENITALIA (MALES ONLY) | | | |
| MUSCULOSKELETAL | | | |
| NECK/SHOULDER | | | |
| ELBOW, WRIST, HAND | | | |
| KNEE, ANKLE, FOOT | | | |
| BACK (SCOLIOSIS) | | | |
| OTHER | | | |

Urinalysis: _____ Other: (if indicated) _____

_____ **Cleared.** I certify that I have examined the above named student and that such exam reveals no condition that would prevent this student from participating in interscholastic sports.

_____ **Not Cleared.** If student not qualified, list reasons.

Doctor's Signature: _____ NC License? Yes _____
 No _____

The following are considered disqualifying until medical and parental releases are obtained: infections, obvious grown retardation, diabetes, jaundice, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or hypertension, enlarged liver or spleen, hernia, musculoskeletal deformity associated with functional loss, history of convulsions or concussions, absence of one kidney, eye, testicle, ovary, etc., or the presence of a shunt, pacemaker, medical device or organ transplant.

(OVER)

PARENT PERMISSION FORM

HISTORY:

Name: _____ Sex: _____ Grade: _____ Date of Birth: _____
 Address: _____ Home Phone: _____
 Mother's Name: _____ Work Phone: _____
 Father's Name: _____ Work Phone: _____
 Personal Physician: _____ Phone: _____
 Sport: _____

- | | | <u>Yes</u> | <u>No</u> | | | | | | | | | | | | | | | |
|-------|---|------------|-----------|-------|------|-------|------|-------|---------|-----------|------|-------|------|------------|-----|--|--|--|
| 1. | Have you ever been hospitalized or had surgery? | Y | N | | | | | | | | | | | | | | | |
| 2. | Are you presently taking any medication or pills? | Y | N | | | | | | | | | | | | | | | |
| 3. | Do you have allergies? (medicine, bees, insects, food, etc.) | Y | N | | | | | | | | | | | | | | | |
| 4. | Have you had any of the following conditions? | | | | | | | | | | | | | | | | | |
| | Passed out or been dizzy during/after exercise? | Y | N | | | | | | | | | | | | | | | |
| | Had chest pain during/after exercise? | Y | N | | | | | | | | | | | | | | | |
| | Had high blood pressure? | Y | N | | | | | | | | | | | | | | | |
| | Been told you had a heart murmur? | Y | N | | | | | | | | | | | | | | | |
| | Racing of your heart or skipped heartbeats? | Y | N | | | | | | | | | | | | | | | |
| | Anyone in your family died of heart problems or suddenly before age 50? | Y | N | | | | | | | | | | | | | | | |
| | Any bleeding/clotting problems? | Y | N | | | | | | | | | | | | | | | |
| 5. | Do you have skin problems (itching, rashes, acne)? | Y | N | | | | | | | | | | | | | | | |
| 6. | Have you had any of the following conditions? | | | | | | | | | | | | | | | | | |
| | Knocked out or unconscious? | Y | N | | | | | | | | | | | | | | | |
| | Had a seizure? | Y | N | | | | | | | | | | | | | | | |
| | Had a head injury? | Y | N | | | | | | | | | | | | | | | |
| | Had a pinched nerve? | Y | N | | | | | | | | | | | | | | | |
| | Had a muscle or heat cramp? | Y | N | | | | | | | | | | | | | | | |
| | Been dizzy or passed out in the heat? | Y | N | | | | | | | | | | | | | | | |
| 7. | Do you have trouble breathing or do you cough during/after activity? | Y | N | | | | | | | | | | | | | | | |
| 8. | Do you have asthma? | Y | N | | | | | | | | | | | | | | | |
| 9. | Do you use any special equipment (neck rolls, pads, braces, mouth or eye guards)? | Y | N | | | | | | | | | | | | | | | |
| 10. | Do you have any problems with your eyes or vision? | Y | N | | | | | | | | | | | | | | | |
| 11. | Have you ever sprained/strained, dislocated, fractured, broken, or had repeated swelling of any bones/joints? Please circle which one(s). | | | | | | | | | | | | | | | | | |
| | <table style="display: inline-table; border: none; vertical-align: middle;"> <tr> <td style="padding: 0 10px;">Head</td> <td style="padding: 0 10px;">Shoulder</td> <td style="padding: 0 10px;">Thigh</td> <td style="padding: 0 10px;">Neck</td> <td style="padding: 0 10px;">Elbow</td> </tr> <tr> <td style="padding: 0 10px;">Knee</td> <td style="padding: 0 10px;">Chest</td> <td style="padding: 0 10px;">Forearm</td> <td style="padding: 0 10px;">Skin/calf</td> <td style="padding: 0 10px;">Back</td> </tr> <tr> <td style="padding: 0 10px;">Wrist</td> <td style="padding: 0 10px;">Hand</td> <td style="padding: 0 10px;">Ankle/foot</td> <td style="padding: 0 10px;">Hip</td> <td></td> </tr> </table> | Head | Shoulder | Thigh | Neck | Elbow | Knee | Chest | Forearm | Skin/calf | Back | Wrist | Hand | Ankle/foot | Hip | | | |
| Head | Shoulder | Thigh | Neck | Elbow | | | | | | | | | | | | | | |
| Knee | Chest | Forearm | Skin/calf | Back | | | | | | | | | | | | | | |
| Wrist | Hand | Ankle/foot | Hip | | | | | | | | | | | | | | | |
| 12. | Do you have any birth deformities? | Y | N | | | | | | | | | | | | | | | |
| 13. | Have you had any other medical problems(diabetes, etc.)? | Y | N | | | | | | | | | | | | | | | |
| 14. | Have you had a medical problem or injury this year? | Y | N | | | | | | | | | | | | | | | |
| 15. | Date of Last Tetanus Shot: _____ Last Measles Immunization: _____ | | | | | | | | | | | | | | | | | |

Explain "Yes" Answers: # _____
 # _____
 # _____
 # _____

PERMISSION AND RELEASE: I, the undersigned parent/guardian of _____ give my approval for my child to participate in the activities of the Athletic Programs. My child is physically able to participate in the program and in doing so, will in no way harm his/her health. I further assume all risk and hazards incidental to the conduct of the activities including transportation to and from the activities. I hereby release, absolve, and hold harmless, the School and the athletic association of the school/parish my child attends, the staff, the organizers, and the supervisors from any and all injury, loss or other damage to us or to the above child arising out of the activities of the program. I also grant permission for treatment deemed necessary to a condition arising during participation in these activities, including medical or surgical treatment recommended by a medical doctor. I understand that every effort will be made to contact me prior to treatment. I certify that the medical history above is accurate to the best of my knowledge.

 Signature of Parent/Guardian

 Date

(Over)