

# Providence Catholic School Medical History

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**The Medical History AND Physical Examination Forms must be completed *annually* by a parent/guardian and student in order for the student to participate in band, dance, PE, ROTC and all athletic activities.** These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in any of the previously mentioned activities.

Explain any "YES" answers on a separate piece of paper. Please circle questions for which you have no answer. Any "YES" answer to questions 1- 28 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physicians assistant, chiropractor or nurse practitioner is required before any participation in **TAPPS or AIAL** practices or competitions, or other school activities requiring a physical.

	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"/>	9. a. Have you ever had unexpected shortness of breath from exercise?	<input type="checkbox"/>	<input type="checkbox"/>	
2. a. Have you been hospitalized overnight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	b. Do you cough, wheeze or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Have you had surgery in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	c. Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Are you currently taking any prescription, over the counter medication or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	d. Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Do you have any allergies (exm. pollen, medicine, food, insect bites)?	<input type="checkbox"/>	<input type="checkbox"/>	10. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	
5. a. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	11. Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	12. Do you use any protective or corrective equipment or devices that aren't usually used for your sport or position (exm. knee brace, special neck roll, foot orthotics, retainer for your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Have you had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	13. a. Have you ever had a sprain, strain or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>		b. Have you ever broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
e. Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>		c. Have you ever had any problems with pain or swelling in muscles, tendons, bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>
f. Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, check appropriate box and explain below			
g. Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip	
h. Has any family member or relative died of heart problems or of a sudden unaccepted death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh	
i. Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome or an abnormal heart rhythm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee	
j. Have you had a severe viral infection (exm, myocarditis, mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf	
k. Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle	
6. Do you have any current skin problems (exm. itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot		
7. a. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	14. a. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Have you ever been knocked out, become unconscious or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	b. Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, how many times? _____			15. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>	
When was the last time? _____			16. Are you under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>	
How severe was each one? Explain below.			17. When was your first menstrual period?			
c. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	_____			
d. Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	18. When was your most recent menstrual period?			
e. Have you ever had numbness or tingling in your arms, legs, hands or feet?	<input type="checkbox"/>	<input type="checkbox"/>	_____			
f. Have you ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	19. How much time elapses from the start of one period to the start of another? _____ days			
8. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	20. How many periods have you had in the last year?			
			_____			
			21. What was the longest time between periods in the last year? _____ days			

If between this date and the beginning of athletic competition or physical activity, any illness or injury should occur that may limit this student's participation, 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 questions are complete and correct. *Failure to provide truthful and complete responses could subject the student in question to penalties determined by the Texas Association of Private and Parochial Schools, Archdiocesan Interscholastic Athletic League, or Providence Catholic School.*

Parent / Guardian Signature \_\_\_\_\_ Student Signature \_\_\_\_\_ Date \_\_\_\_\_

This Medical History Form reviewed by (school use only) Name: \_\_\_\_\_ Date: \_\_\_\_\_

# Providence Catholic School Physical Examination

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

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 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_ (\_\_\_\_\_/\_\_\_\_\_, \_\_\_\_/\_\_\_\_)

Vision: R 20 / \_\_\_\_\_ L 20 / \_\_\_\_\_ Corrected: Y / N Pupils: Equal / Unequal

In keeping with the requirements of the Texas Association of Private and Parochial Schools and Archdiocesan Interscholastic Athletic League, as a minimum requirement, this **PHYSICAL EXAMINATION FORM** must be completed prior to high school and middle school athletic participation each year of school. This form must be completed if there are yes answers to specific questions on the student's annual **MEDICAL HISTORY FORM**.

### GENERAL ANATOMY

	Normal	Abnormal Findings	Initials
Appearance			
Eyes / Ears / Nose / Throat			
Lymph Nodes			
Auscultation of the heart- Supine			
Auscultation of the heart- Sitting			
Pulses			
Lungs			
Abdomen			
Skin			
Liver / Spleen			
Spine			

### MUSCULOSKELETAL

	Normal	Abnormal Findings	Initials
Neck			
Back			
Shoulder / Arm			
Elbow / Forearm			
Wrists / Hands			
Hips / Thighs			
Knees			
Legs / Ankles			
Feet			

### CLEARANCE

\_\_\_\_ Cleared for all sports  
 \_\_\_\_ Cleared after completing evaluation / rehabilitation for: \_\_\_\_\_

Must be cleared by: Dr. \_\_\_\_\_

\_\_\_\_ Not cleared for: (sports) \_\_\_\_\_ Reason: \_\_\_\_\_

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.

Printed/Typed/Stamped Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Signature: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

\*\*\*Physical must be completed before a student participates in any practice (both in-season and out-of-season) or competition.\*\*\*