

2024-25

PHYSICAL FORM

HISTORY FORM--PG 1 of 2

Student's Name: _____	Sex: M / F	Age: ____	Date of Birth: _____	(2024-25) Grade: ____
Address: _____		City: _____		Phone: _____
Sport (s): _____				

Parents, please fill out prior to physical. Explain "Yes" answers below. Circle questions you don't know the answer to.

- | | Yes | No | | Yes | No | | | | | | | | | | | | | | | |
|--|--------------|-----------|--|-----------|-------|---------|--------------|-------|------|-----|-------|------|-----------|-------|-----------|--|--|---|-----|-----|
| 1. Has a doctor ever denied or restricted your participation in sports for any reasons. | ___ | ___ | 24. Do you cough, wheeze or have difficulty breathing during or after exercise? | ___ | ___ | | | | | | | | | | | | | | | |
| 2. Do you have an ongoing medical condition? | ___ | ___ | 25. Anyone in your family who has asthma? | ___ | ___ | | | | | | | | | | | | | | | |
| 3. Are you currently taking any medicines? | ___ | ___ | 26. Ever used an inhaler or taken asthma med? | ___ | ___ | | | | | | | | | | | | | | | |
| 4. Do you have allergies to medicine, foods etc? | ___ | ___ | 27. Were you born w/o or missing a kidney, eye, testicle or any other organ? | ___ | ___ | | | | | | | | | | | | | | | |
| 5. Have you ever passed out or nearly passed out DURING exercise? | ___ | ___ | 28. Ever had infectious mononucleosis within the last month? | ___ | ___ | | | | | | | | | | | | | | | |
| 6. Have you ever passed out or nearly passed out AFTER exercise? | ___ | ___ | 29. Ever had rashes, pressure sores or other skin problems? | ___ | ___ | | | | | | | | | | | | | | | |
| 7. Have you ever had discomfort, pain or pressure in your chest during exercise? | ___ | ___ | 30. Ever had a herpes skin infection? | ___ | ___ | | | | | | | | | | | | | | | |
| 8. Does your heart race or skip beats during exercise? | ___ | ___ | 31. Ever had a head injury or concussion? | ___ | ___ | | | | | | | | | | | | | | | |
| 9. Has a doctor ever told you that you have:
___ High blood pressure ___ A heart murmur
___ High cholesterol ___ A heart infection | ___ | ___ | 32. Been hit in head & been confused or lost memory? | ___ | ___ | | | | | | | | | | | | | | | |
| 10. Has a doctor ever ordered a test for your heart? | ___ | ___ | 33. Ever had a seizure? | ___ | ___ | | | | | | | | | | | | | | | |
| 11. Anyone in your family died for no apparent reason? | ___ | ___ | 34. Do you have headaches with exercise? | ___ | ___ | | | | | | | | | | | | | | | |
| 12. Anyone in your family have a heart problem? | ___ | ___ | 35. Ever had numbness, tingling or weakness in your arms or legs after being hit or falling? | ___ | ___ | | | | | | | | | | | | | | | |
| 13. Has any family member or relative died of heart problems or sudden death before age 50? | ___ | ___ | 36. Ever been unable to move your arms or legs after being hit or falling? | ___ | ___ | | | | | | | | | | | | | | | |
| 14. Anyone in your family have Marfan syndrome? | ___ | ___ | 37. When exercising in the heat, do you have severe muscle cramps or become ill? | ___ | ___ | | | | | | | | | | | | | | | |
| 15. Ever spent the night in a hospital? | ___ | ___ | 38. Has a doctor ever told you that you or someone in your family has sickle cell trait/disease? | ___ | ___ | | | | | | | | | | | | | | | |
| 16. Ever had surgery? | ___ | ___ | 39. Have any problems with your eyes or vision? | ___ | ___ | | | | | | | | | | | | | | | |
| 17. Ever had an injury like a sprain, muscle or ligament tear or tendonitis that caused you to miss practice/game?
<u>If yes, circle affected area below:</u> | ___ | ___ | 40. Do you wear glasses or contacts? | ___ | ___ | | | | | | | | | | | | | | | |
| 18. Ever had any broken/fractured bones or dislocated joints? <u>If yes, circle below:</u> | ___ | ___ | 41. Do you wear protective eyewear? | ___ | ___ | | | | | | | | | | | | | | | |
| 19. Ever had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehab, physical therapy, a brace, cast or crutches? <u>If yes, circle below.</u> | ___ | ___ | 42. Are you happy with your weight? | ___ | ___ | | | | | | | | | | | | | | | |
| <table style="width: 100%; border-collapse: collapse;"> <tr> <td>Head</td><td>Neck</td><td>Shoulder</td><td>Upper arm</td><td>Elbow</td> </tr> <tr> <td>Forearm</td><td>Hand/fingers</td><td>Chest</td><td>Back</td><td>Hip</td> </tr> <tr> <td>Thigh</td><td>Knee</td><td>Calf/shin</td><td>Ankle</td><td>Foot/toes</td> </tr> </table> | Head | Neck | Shoulder | Upper arm | Elbow | Forearm | Hand/fingers | Chest | Back | Hip | Thigh | Knee | Calf/shin | Ankle | Foot/toes | | | 43. Are you trying to gain/lose weight? | ___ | ___ |
| Head | Neck | Shoulder | Upper arm | Elbow | | | | | | | | | | | | | | | | |
| Forearm | Hand/fingers | Chest | Back | Hip | | | | | | | | | | | | | | | | |
| Thigh | Knee | Calf/shin | Ankle | Foot/toes | | | | | | | | | | | | | | | | |
| 20. Ever had a stress fracture? | ___ | ___ | 44. Has anyone recommended you change your weight or eating habits? | ___ | ___ | | | | | | | | | | | | | | | |
| 21. Ever been told that you have or had an x-ray for Atlantoaxial (neck) instability? | ___ | ___ | 45. Do you limit or carefully control what you eat? | ___ | ___ | | | | | | | | | | | | | | | |
| 22. Do you regularly use a brace or assistive device? | ___ | ___ | 46. Do you have any concerns that you would like to discuss with a doctor? | ___ | ___ | | | | | | | | | | | | | | | |
| 23. Do you have asthma or allergies? | ___ | ___ | FEMALES ONLY | | | | | | | | | | | | | | | | | |
| | | | 47. Have you ever had a menstrual period? | ___ | ___ | | | | | | | | | | | | | | | |
| | | | 48. How old were you when you had your first menstrual period? | ___ | ___ | | | | | | | | | | | | | | | |
| | | | 49. How many periods in the last 12 months? | ___ | ___ | | | | | | | | | | | | | | | |
| | | | Explain "Yes" answers here: _____ | | | | | | | | | | | | | | | | | |
| | | | _____ | | | | | | | | | | | | | | | | | |
| | | | _____ | | | | | | | | | | | | | | | | | |

PARENT PERMISSION FOR STUDENT TO PARTICIPATE IN ATHLETIC COMPETITION AND FOR THE PHYSICAL TO BE PERFORMED.
I hereby give consent for my child to receive a physical exam from a doctor for the purpose of completing in athletics at St. Joseph High School and also state, that to the best of my knowledge, my answers to the above questions are complete and correct. I hereby give my consent for my son/daughter to compete in athletic competition. In case this student is injured, the coaches are authorized to have him/her treated. I also understand and agree to adhere to the SJHS provisions in the Athletic Department Handbook.

This form must be returned to the Athletic Department prior to any practice and or play.

Parent / Guardian Signature

Date

Athlete's Signature

Student's Name: _____

Date of Birth: _____

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

Medical	Normal	Abnormal	Initials
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

CLEARED TO PLAY SPORTS **NOT CLEARED TO PLAY SPORTS** **Comments:** _____

Name of Physician (Please print / type): _____ **Date:** _____

Signature of Physician: _____ **Phone:** _____

Address: _____

“This is for athletic participation only and is not intended to be a comprehensive medical evaluation. Certain conditions may exist which may not be identified by this screening. Your personal doctor should be contacted for comprehensive evaluation and screening.”

Student Athletes need a current physical each school year to participate in athletics & cheer.

Consent for Emergency Treatment in Advance

Please print all information

Athlete's Last Name: _____ **First:** _____ **Middle:** _____ **Date of Birth:** _____

Address: _____ **City:** _____ **Phone:** _____

Allergies: _____ **Medications:** _____

Personal Doctor: _____ **Doctor's Phone:** _____

Mother's Name: _____ **Phone:** _____ **Cell:** _____ **Work:** _____ **Ext.** _____

Father's Name: _____ **Phone:** _____ **Cell:** _____ **Work:** _____ **Ext.** _____

Other Emergency Contact, Name: _____ **Phone:** _____ **Cell:** _____

“We, the parents/guardians of the above named athlete, do hereby consent to any and all emergency medical, hospital and surgical care that may be necessary by a physician, without obtaining further consent provided that the hospital is unable to reach us at the phone numbers listed above.”

Today's Date: _____

Parent / Guardian Signature: _____