PHYSICAL EVALUATION FORM

This form is to be used as a tool. It is not mandatory to be used, but proper documentation from a physical exam is.

197 Dover Point Road, Dover, NH 03820 603-742-3206 (fax) 603-749-7822

STUDENT INFORMATION

(to be completed by student or parent)

Student's Name: _____ Sex: _____ Age: _____ Date of Birth: ____/ ____/____

Grade in School: _____ Sport(s): _____

Home Address: _____ Home Phone: (____) _____

Name of Parent/Guardian: _____ E-mail: _____

Person to Contact in Case of Emergency: _____ Relationship to Student: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Family Physician: _____ City/State: _____ Office Phone: (_____) _____

HEALTH HISTORY

Have you ever had, or do you currently have:

a.	Restriction from sports for a health-related problem?	Y / N / Don't Know
b.	An injury or illness since your last exam?	Y / N / Don't Know
c.	A chronic or ongoing illness (such as diabetes or asthma)?	Y / N / Don't Know
	1. An inhaler or other prescription medicine to control asthma?	Y / N / Don't Know
d.	Any prescribed or over-the-counter medications that you take on a regular basis?	Y / N / Don't Know
e.	Surgery, hospitalization or any emergency room visit(s)?	Y / N / Don't Know
f.	Any allergies to medications?	Y / N / Don't Know
g.	Any allergies to bee stings, pollen, latex or foods?	Y / N / Don't Know
	1. If yes, check the type of reaction: □ Rash □ Hives □ Breathing or other anaphylactic reaction	
	2. Take any medication/Epipen for allergy symptoms (list below)	Y / N / Don't Know
h.	Any anemias, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders?	Y / N / Don't Know
i.	A blood relative who died before age 50?	Y / N / Don't Know
j.	Absence of or Disease of One Paired Organ	Y / N / Don't Know

Please note: No student athlete with the absence of one paired organ shall participate in inter-scholastic athletics unless the student athlete provides his/her principal (please send files to the Athletic Trainer) with completion of a medical release completed by a physician, ARNP or by a qualified non-physician health practitioner. The student athlete is required to wear the protective equipment recommended by the medical specialist for all practices and games. It is required that copies of all materials be filed with the NHIAA.

Explain all "Yes" answers here (include relevant dates):

_____

_____

Medications currently prescribed, with dosage and frequency:

Medication Name	Dosage	Frequency

PERMISSION FOR MEDICAL TREATMENT

I _____ parent/guardian of _____

Authorize medical treatment and transportation, if necessary, to a medical facility for my son or daughter in the event I cannot be reached and treatment is necessary due to injury sustained while participating in the Athletic Program of St. Thomas Aquinas High School. Such medical treatment shall be given by a licensed physician in the field of medicine at my expense.

Parent/Guardian Signature _____ Date _____

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EXAM INFORMATION / PROVIDER RECOMMENDATION

To be completed by a licensed provider MD, DO, APN or PA. A copy of the physical exam may be attached.

Height: _____ Weight: _____ % Body Fat (optional): _____ Blood Pressure: _____ Pulse: _____
Vision *Right* _____ *Left* _____ Currently using corrective lenses? □ Y □ N

Most recent immunizations and date administered (please attach a copy of complete copy of immunization records):
Tetanus _____ Date _____

A. Student is cleared for participation in **all** sports without restriction.
B. Student is **withheld clearance** for participation in any sport until evaluation / treatment of:
_____
C. Student is cleared for participation in limited types of sports which exclude the following types of sportscontact:
(check all that apply)
□ CONTACT/COLLISION □ NON-CONTACT/STRENUOUS
□ LIMITED CONTACT □ NON-CONTACT/NON-STRENUOUS

Name of Physician (print) _____

Physician's Signature: _____ Date of Exam: _____