

**St. John Paul II Catholic School
MEDICAL EXAMINATION FORM***

Date: _____

Student: _____ **Grade:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Parent/Guardian: _____ **Phone:** _____

Emergency Cell: _____ **Phone:** _____

Family Physician: _____ **Phone:** _____

The student's parent(s) or guardian(s) grant permission for their middle school student to participate in the following interscholastic sports:

**Medical History
(To be completed by parents)**

Student: _____ **DOB:** _____ **Age:** _____

Place a check in the appropriate column that best answers the question. If "Yes" is the answer, please provide details in the space provided below the table.	Yes **	No	Don't know
1.) Has the athlete ever stopped exercising because of dizziness or passed out during exercise?			
2.) Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise?			
3.) Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint?			
4.) Does the athlete have a history or concussion (getting knocked out)?			
5.) Has the athlete ever suffered a heat-related illness (heat stroke)?			
6.) Does the athlete have a chronic illness or see a doctor regularly for any particular problem?			
7.) Does the athlete take any medication(s)?			
8.) Is the athlete allergic to any medications, food, clothing, bee stings, etc.?			
9.) Does the athlete have only one of any paired organ (eyes, ears, kidneys, testicles, ovaries, etc.)?			
10.) Has the athlete had an injury in the last year that caused him/her to miss 3 or more days of practice or competition?			
11.) Has the athlete had surgery or been hospitalized in the past year?			
13.) Does the athlete wear glasses, contacts, or a dental appliance?			
**Please give details on any "Yes" answers			

PARENTAL PERMISSION

As parent or legal guardian of _____, I hereby give my consent for him/her to practice and play in the sport(s) listed above.

I also grant permission for treatment deemed necessary for 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 agree to the need for a screening medical examination and certify that the medical history above is accurate to the best of my knowledge.

My child is covered under the following insurance policy (please list group name and policy number): _____

**The Diocese or Raleigh requires that all children who participate in after school sports teams have personal health insurance.*

Signature of parent /guardian: _____

Physical Examination

To be completed by a licensed Physician

Height _____ Weight _____ Blood pressure _____

	Normal	Abnormal Findings
1.) Eyes		
2.) Ears, Nose, Throat		
3.) Heart		
4.) Lungs		
5.) Abdomen		
6.) Genitalia (male only)		
7.) Musculoskeletal		
8.) Neurologic		
9.) Skin		

Comments re: Abnormal Findings: _____

Restrictions: _____

<p>I certify that I have examined this student and find him/her medically qualified to compete in the interscholastic sport(s) listed on the reverse side of this form.</p>	<p style="text-align: center;">Physician Stamp</p>
<p>Physician signature</p>	<p>Date of exam</p>