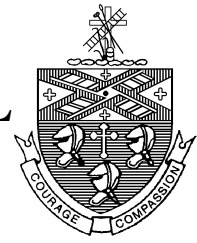




Mrs. Mary Jones, RN
School Nurse

KENNEDY CATHOLIC HIGH SCHOOL



Physical Examination Form Must be completed by Physician and Parent

Student Name _____ Date of Birth _____

Address _____ Entering Grade _____

City, State, Zip _____ Telephone (H) _____

Parent or Guardian _____ Telephone (W) _____

I. General Medical Health History (to be completed by parent or guardian)

Indicate if your child or any member of your family have or have had the following illnesses or disorders by marking (S) for student and (F) for family member in the appropriate box.

	Yes	No	Dates
Asthma			
Respiratory Disorder			
Anemia (including Sickle Cell)			
Hepatitis			
Mononucleosis			
Diabetes			
Thyroid Disorder			
Eye, Ear, Throat Disorder			
High Blood Pressure			
Heart Disorder			
Gastrointestinal Disorder			
Kidney/Genitourinary Disorder			
Epilepsy or Convulsive Disorder			
Concussion/Number _____			
Frequent or Severe Headaches			
History of Fainting or Dizziness			
Heatstroke			
Absence of Paired Organ			
Other Organ Disorder			

*Yes to any of the above, please explain _____

Known Allergies _____

Medications being taken regularly/Purpose _____

	YES	NO
Do you wear Protective Lenses, Eyeglasses or contact Lenses?	___	___
Do you wear any type of dental appliance?	___	___
Have you been hospitalized for any reason?	___	___
Have you ever been denied athletic participation for medical reasons?	___	___
Do you have any other type of illness, injury or condition, which is being monitored by a Doctor?	___	___

*YES to any of the above, please explain _____

SPORT(S) STUDENT IS INTERESTED IN _____

II. Orthopedic History and Information (to be completed by parent or guardian)

Include any major musculoskeletal injury to the following areas:
 Include sprains, dislocations? fractures, and surgery.

	Right	Left	Date	Description of Injury
Foot				
Ankle				
Lower Leg				
Knee				
Thigh				
Hip				
Spine				
Shoulder				
Upper Arm				
Forearm				
Wrist				
Hand				
Head				
Neck				
Other				

Failure to report a medical problem will constitute reason to exclude the student from the Athletic Program. I DECLARE THE ABOVE INFORMATION TO BE ACCURATE,

 Signature of Parent or Guardian

 Date

PHYSICAL EXAMINATION

BMI _____
 Height _____
 Weight _____
 Blood Pressure _____
 Pulse _____
 Vision Screening _____
 Hearing Screening _____

Overall Appearance Healthy _____ Other _____
 Eyes PERRL Other _____
 Heart Rhythm NSR Other _____
 Murmur None Functional _____
 Other _____
 Lungs Clear Other _____
 Abdomen No OMT Other _____
 Scoliosis Screening Normal Other _____

Orthopedic Screening
 Knee ROM/Stability Normal
 Ankle ROM/Stability Normal
 Neck ROM Normal
 Shoulder ROM/Stability Normal
 Hamstring Fingertip distance from floor _____ inches.

Abnormalities: _____

Doctor Recommendations: _____

May participate in all interscholastic competitive sports.

Date of Exam _____

Examining Physician _____ M.D.

Stamp or Print Name and Address

Approved Referred to M.D.