PREPARTICIPATION PHYSICAL FORM for NOTRE DAME HIGH SCHOOL

Name: ______________________________________ Age: ______ Date of Birth ______________________

Grade: ___________ Sports: ____

Personal Physician: __________________________________ Physician's Phone # _____________________

Explain "Yes" answers below"		**Yes**	**No**
1.	Have you ever been hospitalized?	☐	☐
2.	Have you ever had surgery?	☐	☐
3.	Are you presently taking any medications or pills?	☐	☐
4.	Do you have any allergies (medicine, bees or other stinging insects)?	☐	☐
5.	Have you ever passed out during or after exercise?	☐	☐
6.	Have you ever been dizzy during or after exercise?	☐	☐
7.	Have you ever had chest pain during or after exercise?	☐	☐
8.	Do you tire more quickly than your friends during exercise?	☐	☐
9.	Have you ever had high blood pressure?	☐	☐
10.	Have you ever been told that you had a heart murmur?	☐	☐
11.	Have you ever had racing of your heart or skipped heartbeats?	☐	☐
12.	Has anyone in your family died of heart problems or a sudden death before age 50?	☐	☐
13..	Do you have any skin problems (itching, rashes, acne)?	☐	☐
14.	Have you ever had a head injury?	☐	☐
15.	Have you ever been knocked out or unconscious?	☐	☐
16.	Have you ever had a seizure	☐	☐
17.	Have you ever had a stinging, burning or pinched nerve?	☐	☐
18.	Have you ever had heat or muscle cramps?	☐	☐
19.	Have you ever been dizzy or passed out in the heat?	☐	☐
20.	Do you have trouble breathing or do you cough after your activity?	☐	☐
21	Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guard, etc.)	☐	☐
22.	Have you had any problems with your eyes or vision?	☐	☐
23.	Do you wear glasses, contacts or protective eye wear?	☐	☐
24.	Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any of the following bones or joints? Mark all that apply: ☐ Head ☐ Shoulder ☐ Thigh ☐ Neck ☐ Knee ☐ Chest ☐ Hip ☐ Forearm ☐ Shin/Calf ☐ Back ☐ Wrist ☐ Hand ☐ Foot	☐	☐
25.	Have you had any other medical problems (infectious mononucleosis, diabetes, etc)?	☐	☐
26.	Have you had a medical problem or injury since your last evaluation?	☐	☐

Explain "YES" answers:

____

____

____

27. When was your last tetanus shot? ………………………………………………………………………… ____
28. When was your last measles immunization? ……………………………………………………………. ____
29. When was your last menstrual period? ……………………………………………………………………… ____
30. When was your first menstrual period? ……………………………………………………………………….. ____
31. What was the longest time between your periods last year? …………………………………………… ____

I hereby state that to the best of my knowledge, my answers to the above questions are correct.

Signature of Athlete: ___________________________ Signature of Parent: ______________________________

Date _________________ Date _________________

Please take this form with you to your physical examination and have the reverse side completed.

PHYSICAL EXAMINATION – NOTRE DAME HIGH SCHOOL

Name: ____

Height: ____________ Weight: ____________ Blood Pressure: ____________ Pulse: ___________

Vision: Right 20/_____ Left 20/_____ Corrected ☐ Y ☐ N Pupils: Equal _____ Unequal _____

	Normal	Abnormal Findings	Initials
Medical			
Appearance			
Eyes/Ears/Nose/Throat			
Pulses			
Heart			
Lungs			
Abdomen			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Knee			
Leg/ankle			
Foot			
Other			

CLEARANCE:

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: ______________________________________

☐ Not cleared for: __________________________Reason: _________________________________

____

Recommendations: ____

____

____

Name of Physician: ____________________________________ Date of Exam: __________________

(please print clearly)

Address: ____

(Street) *(City)* *(Zip Code)*

Physician's Signature: _________________________________, MD or DO Phone: _________________

Return completed form to:

Notre Dame High School
455 Palma Drive
Salinas, CA 93901

Physician's Office Stamp

Required