

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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you presently taking any medications or pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any allergies (medicine, bees or other stinging insects)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you tire more quickly than your friends during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever been told that you had a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has anyone in your family died of heart problems or a sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have any skin problems (itching, rashes, acne)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever had a head injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever been knocked out or unconscious? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had a seizure | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had a stinging, burning or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever had heat or muscle cramps? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever been dizzy or passed out in the heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you have trouble breathing or do you cough after your activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guard, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you wear glasses, contacts or protective eye wear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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: | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Thigh <input type="checkbox"/> Neck <input type="checkbox"/> Knee <input type="checkbox"/> Chest <input type="checkbox"/> Hip | | |
| <input type="checkbox"/> Forearm <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Foot | | |
| 25. Have you had any other medical problems (infectious mononucleosis, diabetes, etc)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you had a medical problem or injury since your last evaluation? | <input type="checkbox"/> | <input type="checkbox"/> |

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