The Academy of the Holy Cross
SPONSORED BY THE SISTERS OF THE HOLY CROSS

Physical Evaluation Form

Student Name: _____

Please print ***Last*** ***First***

HISTORY QUESTIONNAIRE

This section is to be carefully completed by the student parent(s) or legal guardian.

1. Your Family's Medical History

Diabetes? __ Yes __ No
Allergies? __ Yes __ No
Asthma? __ Yes __ No
Migraine Headaches? __ Yes __ No
Heart Condition? __ Yes __ No
High Blood Pressure? __ Yes __ No
Convulsions or Epilepsy? __ Yes __ No

2. Have you had or do you now have:

Brain Concussion (head injury)? __ Yes __ No
Tendency to lose consciousness? __ Yes __ No
Skull Fracture? __ Yes __ No
Convulsions or Epilepsy? __ Yes __ No
Burners or Stingers or Pinched Nerve? __ Yes __ No
Numbness of Neck, Shoulders or Hands? __ Yes __ No
Temporary loss of vision? __ Yes __ No
Impaired vision in one eye? Both eyes? __ Yes __ No
Hearing loss? __ Yes __ No
Perforated Ear Drum? __ Yes __ No
Recurrent Ear Infections? __ Yes __ No
Discharge From Ear? __ Yes __ No
Sinus Infections? __ Yes __ No
Fracture/Broken Nose? __ Yes __ No
Dentures? __ Yes __ No
Orthodontia (teeth straightened)? __ Yes __ No
Glasses/Contacts? __ Yes __ No

3. Have you had or do you now have:

Asthma? __ Yes __ No
Anemia? __ Yes __ No
Behavioral or Emotional Problem? __ Yes __ No
Birth Defects? __ Yes __ No
Blood in Urine? __ Yes __ No
Bowel Problems? __ Yes __ No
Cerebral Palsy? __ Yes __ No
Diabetes? __ Yes __ No
Heart Condition? __ Yes __ No
Hernia? __ Yes __ No
High Blood Pressure or Cholesterol? __ Yes __ No
Hospitalization? __ Yes __ No
Where/When?
Kidney Problems? __ Yes __ No

4. Have you had or do you now have:

Infectious Diseases? __ Yes __ No
Which? _____
Pneumonia? __ Yes __ No
Mononucleosis? __ Yes __ No
HIV or AIDS? __ Yes __ No
Athlete's Foot? __ Yes __ No
Ringworm? __ Yes __ No
Fungus Infection(s)? __ Yes __ No
Recurrent Rash or Hives? __ Yes __ No
Recurrent Boils or Lesions? __ Yes __ No
Seasonal Allergies (Hay Fever)? __ Yes __ No
Meningitis? __ Yes __ No

5. Do you fatigue easily or quickly with exercise? __ Yes __ No

6. Have you ever fainted during or after exercise? __ Yes __ No

7. Do you frequently suffer from shortness of breath? __ Yes __ No

8. Do you frequently have problems with hyperventilation? __ Yes __ No

9. Do you frequently suffer from chest pains during or after exercise? __ Yes __ No

10. Have you ever experienced skipped heartbeats or racing heart during or after exercise? __ Yes __ No

11. Have you ever been told by a physician that you have a heart murmur? __ Yes __ No

Question 3 continued:

Lead Poisoning? __ Yes __ No
Migraine Headaches? __ Yes __ No
Prematurity? __ Yes __ No
Sickle Cell Disease? __ Yes __ No
Speech Problems? __ Yes __ No
Surgery? __ Yes __ No
Tendency to bruise or bleed easily? __ Yes __ No

12. Have you ever been told you have only one or the absence of one of two function organs? __ Yes __ No
(i.e. kidney, eye, ovary, lung, ear) Specify:

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ORTHOPEDIC QUESTIONS

13. Have you ever had a sprain, strain or swelling after injury? __ Yes __ No
14. Have you broken or fractured any bones or dislocated any joints? __ Yes __ No
15. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? __ Yes __ No
16. Have you had any surgeries in the past two years (explain below)? __ Yes __ No

*Check the appropriate box for **yes answers** to the above questions and explain below*:

__ Head	__ Upper Arm	__ Wrist	__ Hip	__ Shin/Calf	__ Chest
__ Neck	__ Shoulder	__ Hand	__ Thigh	__ Ankle	__ Forearm
__ Back	__ Elbow	__ Finger	__ Knee	__ Foot	

Explain YES answers here:

MEDICATIONS

17. Do you take medication(s) regularly? If YES, please name: _____ __ Yes __ No
18. Do you take medication(s) for emergency use? If YES, please name: _____ __ Yes __ No
19. Are you allergic to any medication(s)? If YES, please name: _____ __ Yes __ No
20. Are you allergic to insect bites? If YES, please specify: _____ __ Yes __ No

21. Have you had any injuries since your last physical for participation in athletics? __ Yes __ No
If YES, please explain:

22. Have you ever had any problems or episodes of Heat Illness, Dehydrations, Heat Exhaustion or Heat Stroke?
If YES, please describe and give date. __ Yes __ No

HEAD & NECK INJURIES

23. **Have you ever had a head injury or concussion (Mild Brain Injury)?** __ Yes __ No
If YES, Please answer the following:

A. Was it necessary to be evacuated to a hospital emergency room? __ Yes __ No
B. Did you see your family physician for this injury? __ Yes __ No
C. How long were you held from activity, sports, and competition? *Please specify:* _____
D. Which symptoms did you experience? *(Please check all that apply)*

__ Headache	__ Dizziness	__ Nausea	__ Vomiting	__ Blurred Vision
__ Poor Balance	__ Confusion	__ Irritability	__ Neck Pain	__ Memory Problems
__ Sadness	__ Nervousness	__ Trouble Sleeping	__ Sensitivity to Light	__ Sensitivity to Noise
__ Difficulty Concentrating				

24. Do you have impaired vision? Which eye? ___ left ___ right __ Yes __ No
25. Have you ever had a neck injury? __ Yes __ No
26. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? __ Yes __ No
27. Have you ever been unable to move your arms or legs after being hit or falling? __ Yes __ No
28. Have you had any illness requiring a physician's services since your last physical? __ Yes __ No
If YES, please describe and give date:

29. Have you been advised by a physician NOT to participate in any activity within the last 12 months? __ Yes __ No
If YES, please describe and give date:

30. Please note any other medical conditions the Health Center/Athletic Training staff should be aware of:

If you would like to further discuss your child's health with the school or school health personnel, please check all that apply:

___ Nurse ___ Teacher ___ Counselor ___ Principal ___ Athletic Trainer

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PHYSICAL EXAMINATION

(This page to be completed by physician/nurse practitioner/physician assistant)

NAME: _____ **D.O.B.** _____/_____/_____ **GRADE:** _____ **DATE OF PHYSICAL:** _____

1. Does the child have a diagnosed medical condition? **YES ___** **NO___**
If YES please describe: _____

2. Does the child have a health condition that may require EMERGENCY ACTION while she is at school or athletic activities? (e.g. seizure, asthma, heart problem, insect sting allergy, bleeding problem, diabetes, other) **YES ____ NO ____**
If YES please describe: _____

3. Is the child on regular medication? **YES ___ NO ___** Name of medication(s): _____
4. Is this child on long term technology assistance? **YES ____ NO ____**

Tuberculin test: Results □ Positive □ Negative _____ (Type) _____ Date (most recent)
Immunizations given on this visit: _____ Date of most recent TETANUS immunization: _____

Height: _____ ft____ in Blood Pressure: _____ Weight: _____lbs Respirations: _____ Pulse: _____

Vision: R 20/_____ L 20/_____ (N/A WITH WITHOUT – Glasses/Contacts)

GENERAL MEDICAL	WNL	ABNORMAL
General Appearance		
Skin		
Nose		
Throat		
Lymph Nodes		
Ears		
Chest		
Heart		
Lungs		
Abdomen		
Hernias		
NEUROLOGICAL		
DTRs		

MUSCULOSKELETAL	WNL	ABNORMAL
Spine (Neck/Back)		
Shoulders		
Arms		
Hands/Wrists		
Elbow		
Hips		
Legs		
Knees		
Ankles		
Feet		
Other		
Sensory		
Other		

○ **CLEARED FOR <u>ALL</u> PHYSICAL ACTIVITY**

○ **NOT CLEARED** → Reason: _____

Note, should the above named athlete have any restrictions, a letter from the individual's physician must accompany this form explaining any and all medical conditions as well as indicate restrictions and level of participation. The AHC Certified Athletic Trainers and administrators reserve the right to make the final decision as to the above named athlete's status regarding participation in interscholastic athletics for The Academy of the Holy Cross high school.

I certify that I have on this date above examined this student and that, on the basis of the examination requested by the school authorities and the students medical history as furnished to me, I have found no reason which would make it inadvisable for this student to compete in supervised athletic activities.
(Note exceptions above)

_____	_____	_____	_____
Physician's Name & Address (stamp or print)	Physician's Signature	Date of Exam	Telephone Number

If the Physician's Assistant (P.A.) or Advance Nurse Practitioner (A.P.N.) performed the exam, Name & Address of collaborating physician or physician group _____

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MEDICAL RELEASE AND PERMISSION TO TREAT

Student Name: _____ ***Sport(s):***_____ **Grade: ___ 9 ___10 ___11 ___12**

BY SIGNING BELOW, I CERTIFY THAT:

I. PARENTAL CONSENT TO TREAT:

A. Permission is hereby granted to The Academy of the Holy Cross Certified Athletic Trainer, Staff, and Coaches to proceed with any necessary Primary and Secondary First Aid. In the event of serious illness or injury, I understand that an attempt will be made to contact me in the most expeditious manner possible. If in the event I cannot be reached, the treatment or referral necessary for the best interest of the above-named participant is given.

B. Permission is hereby granted to The Academy of the Holy Cross Certified Athletic Trainer to proceed with any necessary evaluation, minor medical treatment, and/or rehabilitation of injuries for the above-named student/athlete.

C. Permission is hereby granted to The Academy of the Holy Cross Certified Athletic Trainer to proceed with any necessary use of modalities (i.e. Ice, Moist Heat, Ultrasound, and Electric Stimulation) for the care, treatment, and rehabilitation for the above-named student/athlete's injury(s) administered by The Academy of the Holy Cross Certified Athletic Trainer.

II. CONSENT TO RECEIVE MEDICATION:

Permission is hereby granted to The Academy of the Holy Cross Certified Athletic Trainer to distribute medication (listed below) to the above-named student/athlete. Please indicate if your daughter SHOULD NOT have any of the following medications that are available in the Athletic Training Room for athletes.

Bacitracin	New Skin Liquid Bandage
Biofreeze (analgesic)	Sterile Saline Solution
Betadine Solution (Providone - Iodine 10%)	Tinactic Athletes Foot Cream/Spray/Powder
Flexall (analgesic)	Tuffskin (Adherent Spray)
Gold Bond Powder	Zinc Oxide Ointment
Hydrogen Peroxide	
Hydrocortisone Cream 1.0%, 2.0%, 2.5%	

The above-named student should NOT take/is allergic to the following: _____

III. PARENTAL AUTHORIZATION FOR THE USE & DISCLOSURE OF MEDICAL INFORMATION:

I hereby authorize the Athletic Training Staff to use and disclose our daughter's medical information for purposes related to the evaluation, care, and treatment of athletic-related injuries. I understand that I may revoke this authorization at any time; however, the revocation will not apply to information that has already been released in the response to this authorization. Should I choose to revoke this authorization, I must do so in writing and present my written revocation to the Athletic Training Staff. Unless otherwise revoked, this authorization will be in effect for the entire school year and tryout periods.

IV. STATEMENT OF RISK:

I acknowledge that The Academy of the Holy Cross assumes no responsibility for any risks associated with voluntary participation in school organized athletic, physical education, or other activities. Furthermore, I understand that these sports activities involve risk of serious injury or death. After weighing these risks against the potential benefits my daughter may gain from these activities, I freely and fully accept the risks of athletics on my child's behalf.

V. STATEMENT OF LIABILITY:

In exchange for the opportunity to participate in interscholastic athletics, I freely and fully waive any claim by me, my spouse, or my child against The Academy of the Holy Cross and its employees arising from a sports-related injury or from transportation to/from a sporting event.

VI. STATEMENT CONCERNING TRANSPORTATION:

I understand when The Academy of the Holy Cross does not provide bus or van transportation; my child will be responsible for arranging her own means. I do not hold The Academy of the Holy Cross or its faculty or staff responsible for any problems that may arise from these personal arrangements.

By signing below I certify that I am in agreement with the statements made above, the answers to the questions are true and correct, and that I understand that having passed the physical examination does not necessarily mean that my child is physically qualified to engage in athletics but only that the examiner did not find medical reason to disqualify her at the time of said examination.

_____

Name of Parent/Guardian (Print) Parent/Guardian Signature Date Relation to Athlete