Aquinas Catholic Schools
ATHLETIC MEDICAL FORM

NAME – Last First			BIRTHDATE
PARENT'S NAME	ADDRESS		
HOME TELEPHONE NO.	EMERGENCY TELEPHONE (other than home)		
FAMILY DOCTOR	HOSPITAL OR CLINIC		
SCHOOL	GRADE	HEIGHT	WEIGHT

I understand that this is an athletic physical and does not replace a complete physical. I do not hold this physician responsible for any injury which may occur during my child's participation in athletic events.

_____ _____

PARENT SIGNATURE DATE

PHYSICAL SCREENING REPORT

HEART RATE	HERNIAS	BLOOD PRESSURE

Physician's Comments:

_____ _____

DOCTOR'S SIGNATURE DATE

Aquinas Catholic Schools
SPORTS QUALIFYING PHYSICAL MEDICAL HISTORY QUESTIONNAIRE

<u>Parent</u>: Please complete prior to examination.

Student Name _____ Grade _____ Age _____
School _____Type of Sport/Camp _____

History: YES NO

1. Have you ever fainted? ……_____ _____
   During exercise? ……..._____ _____
   Have you had chest pain during exercise? ……..._____ _____

2. Family history of sudden death? ……..._____ _____
   Before age 35? _____ Before age 50? ……_____ _____
   Cause _____

3. Have you ever had a concussion, loss of consciousness, or head injury? ..._____ _____
   If yes, how many? _____

4. Have you ever had heat stroke or heat exhaustion? ……._____ _____

5. Do you wheeze or cough during or after exercise? ……..._____ _____
   Do you have a history of asthma? ……_____ _____

6. Do you have any allergies? (medications, bee sting, pollens, etc.) …….._____ _____

7. Any sports-related injuries since last exam? ……_____ _____
   If yes, list injuries _____

8. Have you been ill in the last month? ……_____ _____

9. Do you take any medications?
   (including vitamins and nonprescription drugs) ……..._____ _____

10. Have you ever been hospitalized? ……..._____ _____
    Have you ever had surgery? ……_____ _____
    If yes, explain _____

11. If female, last menstrual period _____ Age at onset of first period _____

12. In the last year, what was your lowest weight _____ highest weight _____?
    What do you think is your ideal weight? _____

13. Immunizations: Last tetanus _____
    Last measles, mumps, German measles (MMR) _____

14. Circle any of the following you have had:

Abnormal bleeding/bruising	Anemia	Diabetes
Broken bones/Stress fracture	Dislocation (shoulder, etc.)	Seizures
Hearing impairment	Heart murmur/palpitations	Scoliosis
Hepatitis/Jaundice	High blood pressure	Loss of eye sight
Single organs (kidney, eye, etc.)	Sickle-cell disease	
Rheumatic Fever	Undescended testicle	

Other _____