



PHYSICAL EXAMINATION FORM

SAINT GENEVIEVE HIGH SCHOOL

Last Name:	First Name:
Address:	City/State/Zip:
Telephone Number:	Date of Birth: Month Day Year / /
Emergency Number:	Age: Grade:

HEALTH HISTORY

YES	NO	MEDICAL CONDITION	YES	NO	MEDICAL CONDITION
		Asthma / Allergies / Drug Sensitivity			Kidney Disease
		Diabetes			Muscular Disease
		Diphtheria			Rheumatic Fever
		Ear Infections			Scarlet Fever
		Eczema			Seizures / Convulsions
		Epilepsy			Tuberculosis
		Head and Spinal Injuries			Any medical or treatment now:
		Headaches			Previous sport injury:
		Hernia			Any other medical problems:
		Gastrointestinal Ulcer			Taking medication, if so please list:

If any answer is YES, please explain:

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MEDICAL EXAMINATION

Height: _____

Weight: _____

Vision: (R) _____ / _____ (L) _____ / _____

Hearing: Loss or Chronic ear Pathology _____ (L Ear) _____ (R Ear) _____

Nose: _____

Throat: _____

Dental: Condition _____

bridge work: _____

Heart: lungs _____ B/P _____ Pulse _____

Abdomen: _____ Abnormal Masses _____ Hernia _____

Orthopedic: Posture _____ **R.O.M.** C _____ T _____ L _____

Bone or Joint pathology or weakness: _____

Neurological: Reflexes: P _____ B _____ T _____ A _____

Finger to Nose: _____ Finger/Finger: _____ Stereognosis: _____

Heal to toe: _____ Romberg: _____

EXAMINATION

Was any condition found for which treatment has been recommended?

Should athletic participation be contingent on correction of this condition? **YES** [☐] **NO** [☐]

I approve of full participation in competitive sports subject to the following limitations:

I approve full participation in competitive sports without limitations: **YES** [☐] **NO** [☐]

Physician's Signature

Date

PHYSICIAN'S SEAL

ATHLETIC INFORMATION SHEET

The athletic staff of St. Genevieve High School has deep concern for the health and well-being of each athlete. This form is essential as it will insure that the physical and medical needs of every athlete are met with promptness and according to your directions. Please fill out this form and return to the Main Office.

Last Name:	First Name:
Address:	City/State/Zip:
Home Telephone Number:	<div style="text-align: right; margin-right: 20px;"> Month Day Year </div> Date of Birth: / /
Name and Emergency Telephone Number #1:	Age: Grade:
Name and Emergency Telephone Number #2:	Name and Emergency Telephone Number #2:

Indicate Sport(s):

<input type="checkbox"/> Baseball	In case of an emergency may we select a physician: Yes _____ No: _____ Doctor's Name: _____ Ph #: _____ Insurance Company: _____ Group # _____ Please list any prior illnesses or injuries that would aid the coaching staff/doctor in an emergency: _____ List drug sensitiveness or allergies: _____
<input type="checkbox"/> Basketball	
<input type="checkbox"/> Cross Country	
<input type="checkbox"/> Cheerleading	
<input type="checkbox"/> Dance	
<input type="checkbox"/> Football	
<input type="checkbox"/> Golf	
<input type="checkbox"/> Soccer	
<input type="checkbox"/> Softball	
<input type="checkbox"/> Track & Field	
<input type="checkbox"/> Volleyball	

I, the undersigned, give my consent for my son/daughter to participate in athletics. I authorize St. Genevieve High School to secure any emergency medical care that becomes necessary through participation in athletics or while traveling under the supervision of St. Genevieve High School. I further authorize the school trainer to administer those treatments deemed necessary by the physician. I understand that St. Genevieve High School does not assume responsibility for my child's medical expenses.

Parent Signature: _____ Date: _____