PROVIDENCE
THE COLLEGE PREPARATORY SCHOOL FOR GIRLS GRADES 6-12

PHYSICAL EXAMINATION

This form must be completed for every middle school student, every new student to Providence Catholic School, no matter what grade level, and any student participating in any physical extracurricular activity (ie: PE, Athletics, JROTC, Dance, etc.)

A student cannot try out, practice or participate in these extracurricular activities until there is a Physical Examination form on file.

Student Name: ____________________ DOB: ________________ Age:_______Grade: _______

Parent Name: ____________________ Contact Number: ____________________

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Height__________Weight___________Pulse___________BP________/__________(___________/_________,_________/________)

Vision R 20/_______L 20/________ Corrected Y/N Pupils Equal/Unequal

In keeping with the requirements of the Texas Association of Private and Parochial Schools, as a minimum requirement, this PHYSICAL EXAMINATION FORM must be completed prior to participation in any physical extra-curricular activity. Any student who has a yes answer to any specific question on the annual MEDICAL HISTORY FORM must also have this form completed annually.

GENERAL ANATOMY

	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Auscultation of the heart-Supine			
Auscultation of the heart-Sitting			
Pulses			
Lungs			
Abdomen			
Skin			
Liver/Spleen			
Spine			

MUSCULOSKELETAL

	NORMAL	ABNORMAL FINDINGS	INITIALS
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrists/Hands			
Hips/Thighs			
Knees			
Legs/Ankles			
Feet			

CLEARANCE

____ Cleared for all sports

____ Cleared after completing evaluation/rehabilitation for: ______________________________

Must be cleared by Dr. ______________________________

____ Not cleared for (Sports)_________Reason ______________________________

The following information must be filled in and signed by either a Physician, Physician Assistant licensed by a State Board of Physician Assistant Examiners, or a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners

Printed/Typed/Stamped Name: ______________________________

Address:______________________________

Signature: Date of Exam: ______________________________ ____________________

MEDICAL HISTORY

Student Name____Date of Birth___________________Grade _______

The Medical History must be completed annually by a parent/guardian and student in order for the student to participate in **any physical activities.** These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in physical activity.

Explain any "YES" answers on a separate piece of paper. Please circle question for which you have no answer. Any "YES" answers to questions 1-28 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician's assistant, chiropractor or nurse practitioner is required before any participation in any physical practices, games or matches.

	Yes	No		Yes	No
1.Have you had a medical illness or injury since your last checkup or physical?			23. Have you ever had numbness in your arms, hands, legs or feet?		
2. Have you been hospitalized overnight in the past year?			24. Have you ever had a stinger, burner or pinched nerve?		
3. Have you ever had surgery?			25. Are you missing any paired organs?		
4. Have you ever passed out during or after exercise?			26. Are you presently under a doctor's care?		
5. Have you ever had chest pain during or after exercise?			27. Are you currently taking any prescription or non-prescription medications or inhalers?		
6. Do you get tired more quickly than your friends during exercise?			28. Do you have any allergies?		
7. Have you ever experienced racing of your heart or skipped heartbeats?			29. Have you ever been dizzy before or during exercise?		
8. Have you ever had high blood pressure?			30. Do you currently have any skin problems (itching, acne, wart, fungus or blisters)?		
9. Have you ever had high cholesterol?			31. Have you ever become ill after exercising or working in the heat?		
10. Have you ever been told you have a heart murmur?			32. Have you ever had any problems with your eyes or vision?		
11. Has any family member or relative died of heart problems before age 50?			33. Have you ever gotten unexpectedly short of breath with exercise?		
12. Has any family member or relative died of sudden unexpected death before age 50?			34. Do you have asthma?		
13. Has any family member been diagnosed with enlarged heart (Dilated Cardiomyopathy)?			35. Do you have seasonal allergies that require medical treatment?		
14. Has any family member been diagnosed with Hypertonic Cardiomyopathy?			36. Do you use any special protective or corrective equipment?		
15. Has any family member been diagnosed with Long QT Syndrome?			37. Have you ever had a sprain, strain or swelling after injury?		
16. Has any family member been diagnosed with ion Channelopathy (Brugada syndrome, etc.)			38. Have you ever broken or fractured any bones?		
17. Has any family member been diagnosed with Marfan's Syndrome?			39. Have you ever dislocated any joints?		
18. Have you had a severe viral infection (myocarditis, Mononucleosis, etc.) in the past year?			40. Have you ever had any problems with pain or swelling in muscles, tendons, bones or joint? If yes, please check the appropriate box and explain on a separate sheet of paper Head ☐ Neck ☐ Back ☐ Chest ☐ Shoulder ☐ Upper Arm ☐ Elbow ☒ Forearm ☐ Wrist ☐ Hand ☐ Finger ☐ Hip ☐ Thigh ☐ Knee ☐ Shin/Calf ☐ Ankle ☐ Foot ☐		
19. Has a physician ever denied or restricted you participation in sports for any heart problem?			41. Do you want to weigh more or less than you do now?		
20. Have you ever had a head injury or concussion?			42. Do you lose weight regularly to meet weight requirements for your Extra-Curricular activities?		
21. Have you ever been knocked out, become unconscious or lost your memory?			43. Do you feel stressed out?		
22. Have you ever experienced a seizure?			44. Have you been diagnosed with or treated for Sickle Cell Trait or Sickle Cell Disease?		

45. When was your first menstrual period? __________________
46. When was your most recent menstrual period? ________________
47. How much time elapses from the start of one period to the start of another?_________days.
48. How many periods have you had in the last year? _______________
49. What was the longest time between periods in the last year? _________________days

If between this date and the beginning of activity, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury. I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. ***Failure to provide truthful and complete responses could subject the student in question to penalties determined by the Texas Association of Private and Parochial Schools.***

____Parent/Guardian Signature

Student Signature Date

This Medical form reviewed by (school use only)

Name

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Date

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