Immaculata Catholic School
Athletic Medical Examination Form

Date: _____

Student Name: _____ Grade: _____

City: _____ State: _____ Zip: _____

Parent/Guardian Name: _____ Phone: _____

Emergency Cell: _____ Emergency Phone: _____

Family Physician: _____ Phone: _____

The student's parent(s) or guardian(s) grant permission for their middle school student to participate in the following interscholastic sports:

_____

PARENTAL ATHLETIC PERMISSION

As parent or legal guardian of _____, I hereby give my consent for him/her to practice and play in the sport(s) listed above.

I also grant permission for treatment deemed necessary for a condition arising during participation in these activities, including medical or surgical treatment recommended by a medical doctor. I understand that every effort will be made to contact me prior to treatment.

I agree to the need for a screening medical examination and certify that the medical history above is accurate to the best of my knowledge.

My child is covered under the following insurance policy (please list group name and policy number:

_____

*The Diocese of Raleigh requires that all children who participate in after school sports teams have personal insurance.

Signature of parent/guardian: _____

Medical History

(to be completed by parents)

Student:Name: _____ DOB: _____ Age: _____

Place a check in the appropriate column that best answers the question. If "Yes" is the answer, please provide details in the space provided below the table.	Yes **	No	Don't know
1) Has the athlete ever stopped exercising because of dizziness or passed out during exercise?			
2) Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise?			
3) Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint?			
4) Does the athlete have a history of concussion (getting knocked out)?			
5) Has the athlete ever suffered a heat-related illness (heat stroke)?			
6) Does the athlete have a chronic illness or see a doctor regularly for any particular problem?			
7) Does the athlete take any medication(s)?			
8) Is the athlete allergic to any medications, food, clothing, bee stings, etc?			
9) Does the athlete have only one of any paired organ (eyes, ears, Kidneys, testicles, ovaries, etc)?			
10) Has the athlete had an injury in the last year that caused him/her to miss 3 or more days of practice or competition?			
11) Has the athlete had surgery or been hospitalized in the past year?			
12) Does the athlete wear glasses, contacts, or a dental appliance?			
** Please give details on any "Yes" answers			

Physical Examination

(to be completed by a licensed physician)

Height: _____ Weight: _____ Blood pressure: _____

	Normal	Abnormal Findings
1) Eyes		
2) Ears, Nose, Throat		
3) Heart		
4) Lungs		
5) Abdomen		
6) Genitalia (male only)		
7) Musculoskeletal		
8) Neurologic		
9) Skin		

Comments re: abnormal findings:_____

_____

Restrictions: _____

I certify that I have examined this student and find him/her medically qualified to compete in the interscholastic sport(s) listed on the reverse side of this form.	Physician Stamp
Physician signature	Date of exam