PARTICIPANTS IN INTERSCHOLASTIC ATHLETICS AT CHERRY VALLEY-SPRINGFIELD CENTRAL SCHOOL

You and your parents need to complete this form and bring it with you to your physical.

Student Name _____ **Date of Birth** _____

Address _____ **Grade** _____

Phone Number _____ **Date of last Tetanus Booster** _____

Parent Signature _____ **Date** _____

Please circle yes or no

Do you want to talk to a doctor about a health problem or injury? Y N

Has anyone in your close family ever had:
- high blood pressure? Y N
- diabetes (high blood sugar)? Y N
- allergies (hay fever/asthma)? Y N
- migraine headaches? Y N
- heart trouble? Y N

Has anyone in your family under age 50 died suddenly? Y N

Have you had, or do you have:
- head injury? Y N
- tendency to lose consciousness? Y N
- skull fracture? Y N
- seizures? Y N
- neck injury? Y N

Have you had, or do you have now:
- impaired vision in one eye? Y N
- temporary loss of vision? Y N
- glasses or contacts? Y N

Have you had, or do you have now:
- hearing loss? Y N
- perforated ear drum? Y N
- discharge from ear? Y N
- sinus infection? Y N
- broken nose? Y N
- dental plates (dentures)? Y N
- braces? Y N

Have you had, or do you have now:
- hernia? Y N
- kidney problems? Y N
- (Boys) loss of function or absence of testicles? Y N
- (Girls) menstrual problems? Y N
  - Age of onset of menstruation? _____

Have you had, or do have now:
- bone fracture? Y N
- dislocation?

Have you had, or do have now:
- back injury/frequent backaches? Y N
- knee injury/recurrent pain? Y N
- ankle injury/recurrent pain? Y N
- other joint trouble? Y N
- bone infection? Y N

Have you had, or do you have now:
- diabetes? Y N
- tendency to bleed or bruise easily? Y N
- anemia? Y N
- weight problem? Y N

Have you had, or do you have now:
- asthma (wheezing)? Y N
- hay fever? Y N
- hives or rash? Y N
- allergy to bee stings? Y N
- allergy to any medication? Y N

Do you:
- smoke? Y N
- drink? Y N
- take any medication regularly? Y N
  - if yes, what? _____
- take any medication for emergencies? Y N
  - if yes, what? _____

Have you had, or do you have now:
- heart trouble or murmur? Y N
- high blood pressure? Y N
- persistent cough? Y N
- chest pain with exercise? Y N
- dizziness or faintness with exercise? Y N

Have you had, or do you have now:
- recurrent rash? Y N
- fungus infection? Y N
- athlete's foot? Y N
- recurrent boils? Y N

Do you wish to discuss an emotional problem with the Health Care Provider? Y N

Have you ever been told to give up any sport activity for a health related problem? Y N

Name of Student _____

School _____

Grade _____ Age _____ Height _____ Weight _____ B.P. _____

Significant Past Illness or Injury: _____

_____

Eyes _____ R 20/ L 20/ Ears _____ Hearing _____

Respiratory _____

Cardiovascular _____

Liver _____ Spleen _____ Hernia _____

Musculoskeletal _____ Skin _____

Neurological _____ Genitalia _____

Comments: _____

_____

Complete Immunizations: DPT _____
OPV _____
MMR _____

Other: _____

I certify that I have, on this date, examined this pupil and find him/her physically able to complete in supervised activities listed below:

Baseball Basketball Cheerleading Cross-Country Golf Soccer Softball Track & Field

Other: _____

Date of examination: _____ Signature: _____
Examining Health Care Provider

Health Care Provider's Address: _____

_____

Telephone Number: _____