

# MOUNT SAINT JOSEPH HIGH SCHOOL

## STUDENT PHYSICAL FOR 2010-2011

**GRADE LEVEL (Please circle):**                      **9**                      **10**                      **11**                      **12**

**Student Information**

**Student Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_ **Phone (H):** \_\_\_\_\_  
**Student Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Parent/Guardian #1 Contact:**

Name \_\_\_\_\_ Relationship: \_\_\_\_\_ Email \_\_\_\_\_  
H: \_\_\_\_\_ W: \_\_\_\_\_ C: \_\_\_\_\_

**Parent/Guardian #2 Contact:**

Name \_\_\_\_\_ Relationship: \_\_\_\_\_ Email \_\_\_\_\_  
H: \_\_\_\_\_ W: \_\_\_\_\_ C: \_\_\_\_\_

**\*PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_  
**REQUIRED FOR CONSENT TO PARTICIPATE IN PHYSICAL EDUCATION AND/OR SPORTS PROGRAM(S)**

**Medical Insurance Information** (Student must be covered by health insurance to participate in PE or Sports)

**Insurance Company (name & phone #):** \_\_\_\_\_ **Policy #:** \_\_\_\_\_  
**Policy Holder Name:** \_\_\_\_\_ **Relation to Student:** \_\_\_\_\_  
**Student's Physician:** \_\_\_\_\_ **Physician's Number:** \_\_\_\_\_  
**Student's Dentist:** \_\_\_\_\_ **Dentist's Number:** \_\_\_\_\_

**Family History**

Is there any history in your immediate family of cancer, diabetes, epilepsy, heart disease or any other chronic illnesses?

Please explain: \_\_\_\_\_

**Student Health History** – Please explain any “yes” answers below

Birth Defects?	<b>YES</b>	<b>NO</b>
_____		
Any hospitalizations, surgeries, or serious injuries? <b>Have you ever had any head injuries?</b>	<b>YES</b>	<b>NO</b>
_____		
Any allergies or allergic reactions to foods, drugs, or other agents?	<b>YES</b>	<b>NO</b>
_____		
Any chronic illnesses or medical conditions? Do you take any daily medicine?	<b>YES</b>	<b>NO</b>
_____		
Do you suffer from depression, anxiety, or are you currently under psychiatric care?	<b>YES</b>	<b>NO</b>
_____		
Do you need emergency medication in school? (If yes, please list drug's name and reason for medicine)	<b>YES</b>	<b>NO</b>
_____		

**SYMPTOM REVIEW (To be filled out by student) – In the past year, have you:**

1. Had frequent colds, chronic cough, or ear trouble?	<b>YES</b>	<b>NO</b>	7. Had loss of appetite or unexpected weight loss?	<b>YES</b>	<b>NO</b>
2. Had severe headaches, dizzy spells, or blackouts?	<b>YES</b>	<b>NO</b>	8. Worried a lot? Are there problems at home?	<b>YES</b>	<b>NO</b>
3. Ever fainted after participating in a sports event?	<b>YES</b>	<b>NO</b>	9. Smoked? How much? How long?	<b>YES</b>	<b>NO</b>
4. Are you often tired, weak, fatigued, or short of breath?	<b>YES</b>	<b>NO</b>	10. Slept well?	<b>YES</b>	<b>NO</b>
5. Do you have frequent abdominal pains, or diarrhea?	<b>YES</b>	<b>NO</b>	11. Had painful or swollen joints?	<b>YES</b>	<b>NO</b>
6. Have you noticed blood or painful urination?	<b>YES</b>	<b>NO</b>	12. Had any recurrent skin infections?	<b>YES</b>	<b>NO</b>

Please explain any “yes” answers (except #10) on the following page, specify number.

Space to explain any "yes" answers: \_\_\_\_\_

13. Are there any concerns about your health you would like to discuss with the Doctor? **YES NO**

**Physical Examination**

**Physician Signature:** \_\_\_\_\_ **Exam Date:** \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_ Temp: \_\_\_\_\_

Hearing L \_\_\_\_\_ Hearing R \_\_\_\_\_

Vision: Near Sighted or Far Sighted Visual Acuity L \_\_\_\_\_ R \_\_\_\_\_ Glasses or Contacts \_\_\_\_\_

Date of Last Tetanus Booster \_\_\_\_\_

1. Does the student have a diagnosed medical condition? **YES NO**

If yes, please explain \_\_\_\_\_

2. Does the student have a health condition which may require **EMERGENCY ACTION** while at school? **YES NO**

If yes, please explain \_\_\_\_\_

3. Are there any abnormal findings on examination?

<i>Area of Concern</i>	Yes	No	<i>Area of Concern</i>	Yes	No	<i>Area of Concern</i>	Yes	No
Head			Neurological			Learning Disabilities / Problems		
Eyes			Skin (acne, skin infections)			Mobility		
ENT (hearing aid)			Endocrine			Nutrition		
Dental			Bleeding Disorders			Physical Illness / Impairment		
Respiratory			Immunodeficiency			Speech / Language		
Cardiac			Psychosocial			Vision		
GI			ADD/ADHD			Other:		
GU			Behavior					
Musculoskeletal / Orthopedic			Development					

If yes, please explain below

Findings: \_\_\_\_\_

5. Is the student on medication? **YES NO**

If yes, please indicate: \_\_\_\_\_

6. Any restrictions on activity? **YES NO**

If yes, please specify nature and duration \_\_\_\_\_

7. The student is cleared for sports/physical education? **YES NO**

**8. Please specify below any OTC medicine that can be given to the student while in school. (Discuss with Parent/Guardian)**

<b>Medication</b>	<b>Yes</b>	<b>No</b>	<b>Medication</b>	<b>Yes</b>	<b>No</b>
Ibuprofen			Benadryl		
Acetaminophen			Antacid		
Decongestant			Other:		
Cough Medicine			Other:		