ST. JOHN'S EPISCOPAL SCHOOL
Athletic Participation Physical Examination
Health History from Parent

5th – 8th GRADE ONLY

NAME ___________________________________BIRTHDATE_________GRADE________ M___ F___

Home Address ____City_____________Phone______________
Name of Parent/Guardian____
Name of Pediatrician/Group ____
Office Address___________________________________City_________________Phone______________

Health History (to be completed by parent/guardian and reviewed by examining physician) Please answer the following questions by circling "no" or "yes" and explaining as necessary:

Has this student had a complete physical examination in the past three years?	NO	YES
Has this student ever had a concussion or been unconscious? Explain/ Date_________________	NO	YES
Has this student ever been disqualified from athletic participation for medical reasons?	NO	YES
Does this student have any major medical condition? Explain ___________________________	NO	YES
Has this student had an injury of a muscle, bone, joint, ligament, or tendon? Explain ____	NO	YES
Has this student ever been hospitalized other than surgery? Explain _____________________ ____	NO	YES
Is this student taking any prescription medication? Explain ________________________	**NO**	**YES**

Please indicate the following conditions by circling "no" or "yes" and explaining as necessary:

1	Wears glasses	NO	YES
2	Wears contact lenses	NO	YES
3	Any kind of ear problems? Explain ____________________________	NO	YES
4	Dizziness or Headaches Explain____________________________	NO	YES
5	Seizures, convulsions or fainting spells. Explain ________________________	NO	YES
6	Loose, chipped, or false teeth	NO	YES
7	Heart condition Explain __________________	NO	YES
8	Kidney problems/blood in the urine	NO	YES
9.	Asthma Medication __________________________	NO	YES
10.	Seasonal Allergies	NO	YES
	Bee Allergy	NO	YES
	Food Allergies: __________________________		
	EPI PEN / Auvi-Q	NO	YES

*****OTHER HEALTH ASPECTS THE DOCTOR AND SCHOOL SHOULD BE AWARE OF*****

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This health history is complete and accurate to the best of my knowledge. I understand medical information will be shared with coaches. I understand parents must be on site to provide and administer any medications needed for sports. Coaches cannot administer any medications to students and students cannot carry medication without a completed Parent/Guardian Authorized Health Care Provider Request for Medication on file in the Nurse's Office.

Date: _______________ Parent/Guardian Signature____

*****Do <u>Not</u> Return This Form Unless Reverse Is Completed By Physician*****

mpleted by examining physician or authorized health care provider

Name ______________________ **DOB ________________________**

Height _____________________ **Weight ______________________**

VISION:
Glasses ____NO ____YES

Contacts ____NO ____YES

VITAL SIGNS:
B/P ____________

Pulse __________ Resp _______

URINE:

Sugar ____NEG ____POS

Protein ____NEG ____POS

HEENT:

HEART:

LUNGS:

ABDOMEN:

GENITALIA AND HERNIA:

STRUCTURAL ABNORMALITIES:

(Back, chest, arm, leg deformities)

PHYSICIAN RECOMMENDATIONS:

SCHOOL NURSE FOLLOW-UP:

PHYSICIAN'S REPORT
I hereby certify that this student was examined by me and no physical conditions were detected that would render him/her physically unfit to engage any sport.
Exceptions: None _________ **YES (specify): ______________________________**

Examining Physician ________________________________ Date of Exam ____________