

GREENWICH CATHOLIC SCHOOL
PHYSICAL EXAM FORM FOR SPORTS PARTICIPATION- GREENWICH SCHOOLS
Health History
(To be completed by Parent/Guardian)

Student's Name _____ Address _____

Grade _____ School _____ Sports Being Played (1) _____ (2) _____ (3) _____

All questions must be answered. All "Yes" answers must be explained in the space provided below. Use additional sheet if necessary.

- | Yes | No | Yes | No |
|--------------------------|---|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Allergy – Epi-pen: Yes or No (circle) | | Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Head Injury, Concussion, Loss of Consciousness | | Mononucleosis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Frequent Headaches, Dizziness, Fainting | | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Visual Impairment | | Asthma Inhaler, Yes or No (circle) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Eye Injury, Retinal Detachment | | Recent Viral Illness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Eyeglasses, Contact Lenses | | Orthopedic Injury, i.e., Knee, Ankle, Shoulder |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Hearing Impairment | | Broken Bones |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Dental Bridge, Plate, Braces | | Neck, Spine, or Low Back Injury |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Heart Problem, Murmur, Arrhythmia | | Scoliosis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | High Blood Pressure | | Hospitalizations |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Chest Pain, Fainting During Exercise | | Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Cough, Wheeze, Shortness of Breath
With Exercise or Cold Weather | | Death of Family Member Younger Than 40
Years of Age Due to Illness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Heart Attack or Stroke of Family Member
Younger Than 50 Years of Age | | Skin Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Gastrointestinal Problems | | Heat Stroke, Heat Exhaustion |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Kidney, Urinary Tract Problems | | Medications at Present |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Chronic or Recurrent Illness | | Missing Organs |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Blood Clotting Disorder | | Menstrual Disturbance |
| | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Other Information |

I give permission for release of appropriate information from this sports form to the coach and his/her staff for maintenance of a healthy and safe environment while participating in the sports program. (I will update as appropriate during the school year). In addition, I am aware of the risk inherent in athletics and hereby give permission for my child to tryout and participate.

Signature of Parent or Guardian

Date

PLEASE HAVE PHYSICIAN COMPLETE REVERSE SIDE.

STUDENT'S NAME _____ GD. __ D.O.B. _____ MALE __ FEMALE __

PHYSICIAN'S EXAM

HEIGHT _____ WEIGHT _____ BLOOD PRESSURE _____ SPINAL CURVATURE _____

LAST TETANUS TOXOID BOOSTER WAS ON _____

PHYSICAL EVALUATION

_____ I find this student physically qualified to participate in **ALL** supervised sports.

_____ This student should have the following problems evaluated prior to participation in **ANY** competitive athletics:

This student has health problems, which would prohibit him/her from participating in specific competitive athletics.

YES __ NO __

RESTRICTIONS: CIRCLE BELOW

Badminton	Fencing	Ice Hockey	Soccer	Volleyball
Baseball	Field Hockey	Indoor Track	Softball	Water Polo
Basketball	Football	Lacrosse	Swimming	Wrestling
Cheerleading	Golf	Rugby	Tennis	Other _____
Cross Country	Gymnastics	Skiing	Track	_____

In addition to reviewing the health history and immunization records, this certifies that I have performed a complete Physical Exam including evaluation of the musculo-skeletal system.

THIS EXAM IS VALID FOR THIRTEEN (13) MONTHS FROM THE DATE OF THE EXAM. IF THIS PHYSICAL EXAM EXPIRES DURING A SPORT SEASON, THE STUDENT WILL NOT BE ELIGIBLE TO PARTICIPATE (PRACTICE OR PLAY) UNTIL A NEW EXAM HAS BEEN SUBMITTED AND APPROVED BY THE SCHOOL NURSE.

Signature of Physician Date of Exam Telephone # of Physician Physician (stamp)

Please return this form to the School Nurse before the first day of tryouts.