

**ALBERTUS MAGNUS HIGH SCHOOL**  
**ATHLETIC MEDICAL HISTORY FORM**  
**FOR PARENT USE ONLY**

Sport \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Date of last physical: \_\_\_\_\_ Last Jr./Sr. High Sport played: \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

PLEASE EXPLAIN ANY "YES" ANSWERS IN THE SPACE BELOW:

- |   | YES | NO  |   | YES | NO  |
|---|-----|-----|---|-----|-----|
| 1. Have you ever been hospitalized?   | ___ | ___ | 2. Have you ever had surgery?   | ___ | ___ |
| 3. Have you ever been treated in an emergency room?   | ___ | ___ | 4. Are you presently taking any medication?   | ___ | ___ |
| 5. Do you have any allergies?   | ___ | ___ | 6. Do you have any skin problems?   | ___ | ___ |
| 7. Have you ever had a head injury?   | ___ | ___ | 8. Have you ever had a seizure?   | ___ | ___ |
| 9. Have you ever been knocked out or been unconscious?  | ___ | ___ | 10. Have you ever had a pinched nerve or a burner?  | ___ | ___ |
| 11. Have you ever had heat or muscle cramps?  | ___ | ___ | 12. Have you ever been dizzy or passed out in the heat?   | ___ | ___ |
| 13. Do you cough or wheeze or have trouble breathing during exercise?                                     | ___ | ___ | 14. Do you use any braces, special equipment, pads, eye guards?   | ___ | ___ |
| 15. Have you had any problems with your eyes or vision?   | ___ | ___ | 16. Do you wear glasses or contacts?  | ___ | ___ |
| 17. Have you ever sprained/strained, broke, dislocated, fractured or had swelling to any bones or joints? | ___ | ___ | NOTE L or R: chest/ribs___<br>shin/calf___ head___ shoulder___ neck___<br>elbow___ wrist___ hip___ foot___ ankle___<br>knee___ thigh___ hand/fingers___ |     |     |
| 18. Have you ever passed out during or after exercise?  | ___ | ___ | 19. Have you ever been dizzy during or after exercise?  | ___ | ___ |
| 20. Have you ever had any chest pain during or after exercise?  | ___ | ___ | 21. Have you ever had high blood pressure?  | ___ | ___ |
| 22. Do you tire more quickly than your friends during exercise?   | ___ | ___ | 23. Have you ever been told you have a heart murmur?  | ___ | ___ |
| 24. Have you ever had racing of your heart or skipped beats?  | ___ | ___ | 25. Has anyone in your family died of heart problems before 45?   | ___ | ___ |
| 26. Have you had any other medical problems (asthma, diabetes, sore throats, hepatitis, mononucleosis)?   | ___ | ___ | 27. Have you had a medical problem or injury since your last physical?  | ___ | ___ |
| 28. When was your first menstrual period?   | ___ | ___ | 29. When was your last menstrual period   | ___ | ___ |
| 30. What was the longest time between periods last year?  | ___ | ___ |   |     |     |

EXPLAIN ANY "YES" ANSWER TO THE QUESTIONS ABOVE AND INCLUDE DATES:

\_\_\_\_\_

\_\_\_\_\_

I HEREBY STATE THAT TO THE BEST OF MY KNOWLEDGE, MY ANSWERS TO THE ABOVE QUESTIONS ARE CORRECT.

ATHLETE'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**THIS IS THE ONLY FORM YOU MAY USE FOR SPORTS.**

**ALBERTUS MAGNUS HIGH SCHOOL**  
**ATHLETIC PHYSICAL EXAMINATION**  
**FOR PHYSICIAN USE ONLY**

Name \_\_\_\_\_ Date of Exam \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Body Fat: \_\_\_\_\_ Additional Tetanus Date: \_\_\_\_\_

Vision: R \_\_\_\_\_ L \_\_\_\_\_ with correction BMI \_\_\_\_\_

R \_\_\_\_\_ L \_\_\_\_\_ without

Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_ Respiratory Rate: \_\_\_\_\_

Hearing: R \_\_\_\_\_ L \_\_\_\_\_ Urinalysis: A \_\_\_\_\_ S \_\_\_\_\_

**MEDICAL:**

	<u>Normal</u>	<u>Abnormal Findings</u>		<u>Normal</u>	<u>Abnormal Findings</u>
Nose/Throat/Mouth	_____	_____	Head/Scalp	_____	_____
Neck	_____	_____	Heart	_____	_____
Eyes/Ears	_____	_____	Lungs	_____	_____
Abdomen	_____	_____	Skin	_____	_____
Genitalia	_____	_____	Hernia	_____	_____

**ORTHOPEDIC:**

Neck	_____	_____	Shoulders	_____	_____
Arm	_____	_____	Elbow	_____	_____
Forearm	_____	_____	Wrists	_____	_____
Head/Fingers	_____	_____	Back/Shoulders	_____	_____
Hips	_____	_____	Leg	_____	_____
Knees	_____	_____	Calves	_____	_____
Ankles	_____	_____	Feet/Toes	_____	_____

**FUNCTIONAL TESTS:**

Spine ROM	_____	_____	Jump	_____	_____
Hop	_____	_____	Squat	_____	_____
Duck Walk	_____	_____			

This certifies that \_\_\_\_\_ is physically qualified to participate in the following categories of completion during the school year 20\_\_\_\_-20\_\_\_\_.

Any unmarked categories indicates disqualification for the particular group of sports activities.

**CONTACT/COLLISION**

**LIMITED CONTACT/  
IMPACT**

**STRENUOUS  
NONCONTACT**

**NONSTRENUOUS  
NONCONTACT**

Field Hockey  
Football  
Ice Hockey  
Lacrosse  
Soccer  
Wrestling

Baseball  
Basketball  
Diving  
Gymnastics  
Handball  
Skiing  
Cross-country  
Downhill  
Softball  
Volleyball

Crew  
Cross-country  
Track and Field  
Swimming  
Tennis

Archery  
Bowling  
Golf  
Riflery

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

(OVER)