# ST. RAPHAEL CATHOLIC SCHOOL
## MEDICAL EXAMINATION FORM*

Date: _____

Student: _____ Grade: _____

Address: _____

City: _____ State: _____ Zip: _____

Parent/Guardian: _____ Phone: _____

***Emergency contact phone number (cell phone) Phone:*** _____

Family Physician _____ Phone: _____

**The student's parent(s) or guardian(s) grant permission for their student to participate in the following interscholastic sports:**

_____

### Medical History
### (To be completed by parents)

**Student:** _____ **DOB:** _____ **Age:** _____

| Place a check in the appropriate column that best answers the question. If "Yes" is the answer, please provide details in the space provided below the table. | **Yes **** | **No** | **Don't know** |
|---|---|---|---|
| 1.) Has the athlete ever stopped exercising because of dizziness or passed out during exercise? | | | |
| 2.) Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise? | | | |
| 3.) Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint? | | | |
| 4.) Does the athlete have a history or concussion (getting knocked out)? | | | |
| 5.) Has the athlete ever suffered a heat-related illness (heat stroke)? | | | |
| 6.) Does the athlete have a chronic illness or see a doctor regularly for any particular problem? | | | |
| 7.) Does the athlete take any medication(s)? | | | |
| 8.) Is the athlete allergic to any medications, food, clothing, bee stings, etc.? | | | |
| 9.) Does the athlete have only one of any paired organ (eyes, ears, kidneys, testicles, ovaries, etc.)? | | | |
| 10.) Has the athlete had an injury in the last year that caused him/her to miss 3 or more days of practice or competition? | | | |
| 11.) Has the athlete had surgery or been hospitalized in the past year? | | | |
| 13.) Does the athlete wear glasses, contacts, or a dental appliance? | | | |
| ******Please give details on any "Yes" answers | | | |

# PARENTAL PERMISSION

**As parent or legal guardian of _____, I hereby give my consent for him/her to practice and play in the sport(s) listed on the other side of this form.**

**I also grant permission for treatment deemed necessary for a condition arising during participation in these activities, including medical or surgical treatment recommended by a medical doctor. I understand that every effort will be made to contact me prior to treatment.**

**I agree to the need for a screening medical examination and certify that the medical history above is accurate to the best of my knowledge.**

**My child is covered under the following insurance policy (please list group name and policy number): _____**

***The Diocese of Raleigh requires that all children who participate in after school sport teams have personal health insurance.***

**Signature of parent /guardian: _____**

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## Physical Examination

**To be completed by a licensed Physician**

**Height _____ Weight _____ Blood pressure _____**

| | Normal | Abnormal Findings |
|---|---|---|
| 1.) Eyes | | |
| 2.) Ears, Nose, Throat | | |
| 3.) Heart | | |
| 4.) Lungs | | |
| 5.) Abdomen | | |
| 6.) Genitalia (male only) | | |
| 7.) Musculoskeletal | | |
| 8.) Neurologic | | |
| 9.) Skin | | |

**Comments re: Abnormal Findings: _____**

**Restrictions: _____**

| | |
|---|---|
| **I certify that I have examined this student and find him/her medically qualified to compete in the interscholastic sport(s) listed on the reverse side of this form.** | **Physician Stamp** |
| **Physician signature** | **Date of exam** |