ST ROBERT BELLARMINE CYO PHYSICAL EXAMINATION FORM

Please answer all questions thoroughly. This information is important for your child's safety. All information will be kept confidential unless needed in an emergency situation. The Health History portion must be signed by a licensed physician or nurse practitioner.

Name: _____ Phone: (____) - _____

Address (Street, City, Zip) _____

Date of Birth:_____ Sex_____ Age_____ Grade_____

HEALTH HISTORY INFORMATION

Height_____ Weight _____ Blood Pressure _____

Have you experienced any of the following: (Please provide dates on space provided)

Allergy to Bee Stings	Developmental Disability	Hernia
Allergy to Medication	Diabetes	Hypertension
Arthritis	Ear Infection	Lung Disease
Back Injury	Epilepsy	Kidney Problems
Balance Problems	Fainting Spells	Rheumatic Fever
Bladder Control Problems	Frequent Colds	Seizures
Bronchitis	Head Injury	Sleep Walking
Chicken Pox	Heart Disease/Defect	Stomach Upsets
Constipation	Hemophilia	Stroke
Other	Other	Other

If you check any of the above, please explain: _____

_____

Do you have any sensory, physical, or cognitive disabilities? Yes___ No ___ If yes, explain: _____

_____

Do you have any mobility impairment? Yes ___ No ___ If yes, explain: _____

_____

Is there evidence of a hernia? Yes ___ No ___ If yes, would athletic competition be injurious?_____

Heart Condition: (circle one) Satisfactory Unsatisfactory Lung Condition: (circle one) Satisfactory Unsatisfactory

Is the general condition of the eyes, ears, feet, mouth, and nose satisfactory? Yes ___ No ___ If no, explain: _____

_____

Other Allergic Reactions?_____

Any Dietary Restrictions? _____

Has the participant been treated or hospitalized in the last 24 months? If yes, for what injury or illness?_____

_____

Participating Sports: Soccer ____ Volleyball ____ Basketball ____ Baseball ____ Softball ____ Track ____

I certify that on this day of _____, I have examined the above individual and recommend HIM/HER as physically able to compete in all the supervised athletic activities listed above except for:_____.

Signature of Examining Physician/Practitioner: _____ Phone: (____) - _____