ATHLETIC DEPARTMENT
ST. JOSEPH BY-THE-SEA HIGH SCHOOL
HEALTH AND MEDICAL RECORD

Last Name | First | Middle | Team/Level

Name_____ Date of Birth_____

Address_____

City_____ State_____ Zip Code_____

Team/Level_____

In case of emergency, notify:

Name_____ Relationship_____

Address_____

Home Phone_____ Work Phone_____

Other person to contact:

Name_____ Phone_____

HEALTH HISTORY

Have you had: (Mark "past" or "not" or leave blank)

Sinus trouble	_____	Asthma	_____	Frequent diarrhea	_____
Rheumatic Fever	_____	Earache/Infection	_____	Fainting spells	_____
Epilepsy	_____	Tuberculosis	_____	Diabetes	_____
Kidney disease	_____	Heart Trouble	_____	For girls:	_____
Hay Fever	_____	Severe stomach aches	_____	Menstrual problems	_____

Other allergies or reaction to any medication?_____

Do you tire easily?_____

Do you get out of breath easily?_____

Have you had more than a brief minor illness or injury during the past year? _____

*If so, what?*_____

*Any condition now requiring regular medication or treatment?*_____

Operations or serious injuries (dates) _____

*Any restriction of activity for medical reasons?*_____

*Explain:*_____

Parents' Authorization:

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me and the physician. In the event I cannot be reached in an emergency, I hereby give permission to the physician/medical facility selected by the school/coach in charge to hospitalize, secure proper anesthesia, or to order injection or surgery for my son/daughter.

*Signature*_____ *Date*_____

(Parent / Guardian)

MEDICAL EVALUATION

TO BE FILLED IN BY A PHYSICIAN

PHYSICAL EXAMINATION:

	NORMAL		NORMAL		
Height_____	[ ]	Lungs	[ ]	Urinalysis:	
Weight_____	[ ]	Heart	[ ]	Sugar?	_____
Eyes	[ ]	Abdomen	[ ]	Albumin?	_____
Ears	[ ]	Genitalia	[ ]		
Nose	[ ]	Extremities	[ ]	Blood Pressure	_____
Throat	[ ]	Posture		If indicated:	
Teeth	[ ]	(Spine)	[ ]	Blood Count	_____
Dentures	[ ]	Skin	[ ]	Chest Plate	_____
Braces	[ ]			Tuberculin Test	_____

Blood Type: _____

General Appraisal_____

_____

I certify that I have today reviewed the health history and examined this person and find him/her physically fit to participate in:

Baseball	_____	Lacrosse	_____
Basketball	_____	Soccer	_____
Bowling	_____	Softball	_____
Cheerleading	_____	Swimming	_____
Football	_____	Tennis	_____
Golf	_____	Track	_____
Ice Hockey	_____	Volleyball	_____
		Wrestling	_____

Recommendations and/or restrictions (if none, so state):

_____

_____

PHYSICIAN'S SIGNATURE:

DATE_____

SIGNATURE_____

TELEPHONE_____(_____)_____
AREA CODE **NUMBER**

ADDRESS_____

CITY & STATE_____
ZIP

Return this form on Orientation Day in June