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

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.

08/19 rev. __________(PHN initials)

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

PHYSICIAN'S EXAM

HEIGHT_________ WEIGHT__________ BLOOD PRESSSURE _______________ 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.

Revised: 08/19

Form reviewed by:_______________