St. John Bosco Catholic School
16035 S. 48th St. Phoenix, AZ 85048
480-219-4848

(The Parent or Guardian should fill out this form with assistance from the student athlete.)

Name ______________________ Sex _____ Age _____ Date of Birth __________ Grade _____

Address ______________________________________ Phone ______________

Personal Physician ______________________ Hospital Preference ______________________

Explain "Yes" answers below.
Circle questions you don't know the answers to.

Question	Yes	No
Have you had a medical illness or injury since your last check-up or sports physical?	☐	☐
Do you have an ongoing or chronic illness?	☐	☐
Are you currently being treated for an injury or condition?	☐	☐
Have you ever been hospitalized overnight?	☐	☐
Have you ever had surgery?	☐	☐
Are you currently taking any prescription or non-prescription (over the counter) medications, pills or using an inhaler? ______________	☐	☐
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
Do you have any allergies to medications? ______________	☐	☐
Do you have any allergies to pollen, food or stinging insects? ______________	☐	☐
Have you ever had a rash or hives develop during or after exercise?	☐	☐
Have you ever passed out during or after exercise?	☐	☐
Have you ever been dizzy during or after exercise?	☐	☐
Have you ever had chest pain during or after exercise?	☐	☐
Do you get tired more quickly than your friends during exercise?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Have you had high blood pressure or high cholesterol?	☐	☐
Have you ever been told you have a heart murmur?	☐	☐
Have you had a severe viral infection (i.e., mononucleosis or myocarditis) within the last month?	☐	☐
Has a doctor ever denied or restricted your participation in sports for any heart problems?	☐	☐
Has anyone in your immediate family had the following conditions? Diabetes ☐ Heart disease ☐ Sudden death ☐ High blood pressure ☐		
Do you have any current skin problems (itching, rashes, acne, warts, fungus or blisters?	☐	☐
Have you ever had a seizure?	☐	☐
Do you have frequent or severe headaches?	☐	☐
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐	☐
Have you ever become ill from exercising in the heat?	☐	☐
Have you ever had a pinched nerve?	☐	☐

Question	Yes	No
Do you cough, wheeze or have trouble breathing during or after activity?	☐	☐
Do you have asthma?	☐	☐
Do you use an inhaler?	☐	☐
Do you have seasonal allergies that require medical treatment?	☐	☐
Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on teeth or hearing aid)?	☐	☐
Have you had any problems with your eyes or vision?	☐	☐
Do you wear glasses, contacts or protective eyewear?	☐	☐
Have you ever had a strain, sprain or swelling after injury?	☐	☐
Have you ever fractured any bones or dislocated any joints?	☐	☐
Have you ever had any problems with pain or swelling in your muscles, tendons, bones or joints?		

If yes, check appropriate box below.

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper arm	☐ Calf	☐ Foot

Question	Yes	No
Do you want to weigh more or less than you do now?	☐	☐
Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
Do you feel stressed?	☐	☐
Do you or have you ever used Smokeless tobacco ☐ Cigarettes ☐ Alcohol ☐ Recreational drugs ☐	☐	☐

FEMALES ONLY

When was your first menstrual period? ______________________

When was your most recent menstrual period? ______________________

How much time do you usually have from the start of one period to the start of another? ______________________

How many periods have you had in the last year? ____________

What was the longest time between periods last year? ______________

Explanation: ____

____

____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. I understand and acknowledge that truthful and accurate information is essential in properly determining whether the student should be cleared for athletic participation.

______________________ ______________________ ______________
Signature of Parent/Guardian Signature of Student Athlete Date

ANNUAL PRE-PARTICIPATION PHYSICAL EVALUATION

Name ______________________________ Date of Birth ________________ Age ____________ Sex _____

Height ___________ Weight ___________ Pulse ___________ BP _____/_____ (_____/_____. _____/ _____)

Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary *			
Skin			
MUSCOLOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

*Having a third party present is recommended for the genitourinary examination.

Notes: ____

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❑ Cleared without restriction

❑ Not cleared for: ❑ All sports ❑ Certain sports Reason: ________________________

Recommendations: ____

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____

Name of Physician (print) ______________________________________ Date ____________________

Address ____ Phone ____________________

Signature of Physician ____, MD / DO / NP / PA-C

(To be completed by Physician.)