# CATHEDRAL CATHOLIC HIGH SCHOOL

*Home of the Dons*

## ATHLETIC RELEASE AND PHYSICAL FORM (2019-2020)

*This form is not valid if completed before Friday, June 7, 2019*

| NAME: | GRADE: | AGE: |
|---|---|---|

## PART 1. MEDICAL HISTORY (*TO BE COMPLETED BY PARENT*)

*This information is confidential and for use by CCHS medical personnel only, unless otherwise specified. Any falsification of past medical records may disqualify athletes and/or void insurance coverage.*

**Does your student currently have or has ever had any of the following:**

| YES | NO | CONDITION | EXPLANATION OF "YES" IS REQUIRED (please include dates) |
|---|---|---|---|
| | | ADHD / Depression | MEDICATIONS: |
| | | Allergies (Drug, Food, etc.) | LIST: EPI-PEN: ☐ YES ☐ NO |
| | | Asthma | MEDICATIONS: |
| | | Broken Bones | BODY PART/DATE OF INJURY: |
| | | Concussion / Head Injury | DATES: |
| | | Corrective Lenses | ☐ CONTACT LENSES ☐ GLASSES ☐ FOR COMPETITION |
| | | Diabetes | FORM OF TREATMENT: |
| | | Dizziness / Fainting | |
| | | Epilepsy / Seizure Disorder | MEDICATIONS: |
| | | Headaches / Migraines | MEDICATIONS: |
| | | Hearing / Speech Disorder | |
| | | Heart Arrhythmias (Irregular or abnormal heart beat) | |
| | | Heart Murmur | |
| | | Heat Illness | DATES OF TREATMENT: HOSPITALIZATION: ☐ YES ☐ NO |
| | | Hepatitis / Jaundice | |
| | | High Blood Pressure | MEDICATION: |
| | | Kidney or Bladder Problems | |
| | | Missing Organs | |
| | | Mononucleosis | DATE: |
| | | Stomach Conditions or Ulcer | |
| | | Surgeries | DATES: |
| | | Rheumatic Fever | |
| | | Current Medications | LIST: |
| | | Other Medical Conditions | LIST: |

| SPORTS RELATED INJURIES | |
|---|---|
| Please list all sports related injuries within the last 2 years not previously mentioned | |

*To the best of my knowledge, the medical history provided herein is correct and complete. I know of no reason, not recorded herein, to restrict activity. In case of injury or emergency, I hereby give consent for my son/daughter to be cared for by a physician, nurse, or athletic trainer using treatment deemed necessary. This permission includes emergency surgery and admission to the hospital in addition to medications and X-rays.*

PARENT/GUARDIAN NAME (PRINT) PARENT/GUARDIAN SIGNATURE DATE

| PARENT CONTACT INFORMATION | | |
|---|---|---|
| HOME PHONE: | CELL PHONE: | WORK PHONE: |

| PHYSICIAN/INSURANCE INFORMATION | |
|---|---|
| PRIMARY PHYSICIAN: | PHYSICIAN'S CONTACT NUMBER: |
| INSURANCE CARRIER: | POLICY NUMBER: |

## PART 2. CATHEDRAL CATHOLIC HIGH SCHOOL PHYSICAL FORM

***Please note: Physical exam must be performed and signed by a Physician (MD/DO), Physician's Assistant (PA), or Nurse Practitioner (NP) licensed in the State of California.***

| **DATE OF EXAM:** | |
|---|---|

***Exam MUST be completed on or after Friday, June 7, 2019***

| NAME: | | DATE OF BIRTH: |
|---|---|---|
| HEIGHT: | WEIGHT: | BMI: |
| AGE: | GRADE: | SEX: ☐ MALE / ☐ FEMALE |
| SPORTS: | | |

| VITAL SIGNS | | |
|---|---|---|
| BLOOD PRESSURE: | PULSE: | RESPIRATIONS: |

| VISION | | |
|---|---|---|
| RIGHT EYE: | LEFT EYE: | PERL: |
| TESTED WITH CORRECTIVE LENSES: ☐ YES ☐ NO | ☐ GLASSES ☐ CONTACTS | |

| PHYSICAL EXAM | | | |
|---|---|---|---|
| | NORMAL | ABNORMAL | COMMENTS |
| APPEARANCE/SKIN | | | |
| EYES/EARS/NOSE/THROAT | | | |
| HEAD/NECK/LYMPHATICS | | | |
| CARDIOVASCULAR | | | |
| RESPIRATORY | | | |
| GASTROINTESTINAL | | | |
| GENITAL/URINARY | | | |
| MUSCULOSKELETAL | | | |
| NEUROLOGICAL | | | |

| **PHYSICIAN CLEARANCE (*Please check one*)** | | |
|---|---|---|
| | **CLEARED FOR UNLIMITED PARTICIPATION / NO RESTRICTIONS** | |
| | LIMITED PARTICIPATION | *EXPLAIN*: |
| | WITHHELD FROM PARTICIPATION | *EXPLAIN*: |

*I have reviewed the medical history and given a thorough physical examination to the above-named student. I certify that all the important medical information has been included, and the information is complete and accurate.*

*PHYSICIAN'S SIGNATURE: _____ DATE: _____
***(*Must be licensed in the State of California)***

PHYSICIAN'S NAME (print): _____
PHYSICIAN'S PHONE NUMBER: _____

***PHYSICIAN'S STAMP OR BUSINESS CARD**:
***(*Required)***

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