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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