



CATHEDRAL CATHOLIC

HIGH SCHOOL

Home of the Dons

ATHLETIC RELEASE AND PHYSICAL FORM (2017-2018)

This form is not valid if completed before Monday, June 5, 2017

NAME:	GRADE:	AGE:
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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: <input type="checkbox"/> YES <input type="checkbox"/> NO
		Asthma	MEDICATIONS:
		Broken Bones	BODY PART/DATE OF INJURY:
		Concussion / Head Injury	DATES:
		Corrective Lenses	<input type="checkbox"/> CONTACT LENSES <input type="checkbox"/> GLASSES <input type="checkbox"/> 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: <input type="checkbox"/> YES <input type="checkbox"/> 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 Monday, June 5, 2017*

NAME:		DATE OF BIRTH:
HEIGHT:	WEIGHT:	BMI:
AGE:	GRADE:	SEX: <input type="checkbox"/> MALE / <input type="checkbox"/> FEMALE
SPORTS:		

VITAL SIGNS		
BLOOD PRESSURE:	PULSE:	RESPIRATIONS:

VISION		
RIGHT EYE:	LEFT EYE:	PERL:
TESTED WITH CORRECTIVE LENSES: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> GLASSES <input type="checkbox"/> CONTACTS		

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

PHYSICIAN CLEARANCE <i>(Please check one)</i>	
<input type="checkbox"/>	CLEARED FOR UNLIMITED PARTICIPATION / NO RESTRICTIONS
<input type="checkbox"/>	LIMITED PARTICIPATION EXPLAIN: _____
<input type="checkbox"/>	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)*