



# ARCHBISHOP SPALDING HIGH SCHOOL

## Pre-participation Physical Evaluation Page 2

Date Of Exam \_\_\_\_\_ Sport(s) \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Grade \_\_\_\_\_ Personal physician \_\_\_\_\_ Phone \_\_\_\_\_

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

		Yes	No			Yes	No																
1.	Has a doctor ever denied or restricted your participation in sport for any reason?			27.	Were you born without or are you missing a kidney, eye, testicle or any other organ?																		
2.	Did you have an ongoing medical condition (diabetes, asthma, etc)?			28.	Have you had infectious mononucleosis (mono) in the last month?																		
3.	Are you currently taking any prescription or non-prescription (over the counter) medicines or pills?			29.	Do you have any rashes, pressure sores, or other skin problems?																		
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?			30.	Have you had a herpes skin infection?																		
5.	Have you ever passed out or nearly passed out DURING exercise?			31.	Have you EVER had a HEAD INJURY OR CONCUSSION?																		
6.	Have you ever passed out or nearly passed out AFTER exercise?			32.	Have you been hit in the head and been confused, lost memory, had a headache, dizziness or trouble concentrating?																		
7.	Have you ever had discomfort, pain or pressure in your chest during exercise?			33.	Have you ever had a seizure?																		
8.	Does your heart race or skip beats during exercise?			34.	Do you have headaches with exercise?																		
9.	Has a doctor ever told you that you have (Check all that Apply) <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection			35.	Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?																		
10.	Has a doctor ever ordered a test for your heart? (ECG, etc.)			36.	Have you ever been unable to move your arms or legs after being hit or falling?																		
11.	Has anyone in your family died for no apparent reason?			37.	When exercising in the heat, do you have severe muscle cramps or become ill?																		
12.	Does anyone in your family have a heart problem?			38.	Has a doctor ever told you that you or someone in your family has SICKLE CELL TRAIT or SICKLE CELL DISEASE?																		
13.	Has any family member or relative died of heart problems or of sudden death before age of 50?			39.	Have you had any problems with your eyes or vision?																		
14.	Does anyone in your family have Marfan's Syndrome?			40.	Do you wear glasses or contacts?																		
15.	Have you ever spent the night in a hospital?			41.	Do you wear protective eyewear such as goggles or a face shield?																		
16.	Have you ever had surgery?			42.	Are you happy with your weight?																		
17.	Have you ever had an injury like a sprain, muscle or ligament tear or tendinitis that caused you to miss practice or a game? If yes, circle the affected area below.			43.	Are you trying to gain or lose weight?																		
18.	Have you ever had any broken bones or dislocated joints? If yes, circle the affected area below.			44.	Has anyone recommended you change your weight or eating habits?																		
19.	Have you had a bone or joint injury that required x-rays MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, cast or crutches? If yes, circle the affected area below.			45.	Do you limit or carefully control what you eat?																		
	<table border="1"> <tr> <td>Head</td> <td>Neck</td> <td>Shoulder</td> <td>Upper Arm</td> <td>Elbow</td> <td>Forearm</td> <td>Hand/ Finger</td> <td>Chest</td> </tr> <tr> <td>Upper Back</td> <td>Lower Back</td> <td>Hip</td> <td>Thigh</td> <td>Knee</td> <td>Calf/ Shin</td> <td>Ankle</td> <td>Foot/ Toes</td> </tr> </table>	Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Finger	Chest	Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes			46.	Do you have any concerns you would like to discuss with the doctor?		
Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Finger	Chest																
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes																
20.	Have you ever had a stress fracture?			<b>FEMALES ONLY:</b>																			
21.	Have you been told that you have or have had an x-ray for an atlanto-axial instability (neck)?			47.	Have you ever had a menstrual period?																		
22.	Do you regularly use a brace or assistive device?			48.	How old were you when you had your first menstrual period?																		
23.	Has a doctor ever told you that you have asthma or allergies?			49.	How many have you had in the last year?	___/	<b>12</b>																
24.	Do you cough or have difficulty breathing during or after exercise?			Explain Yes answers here:																			
25.	Is there anyone in your family that has asthma?																						
26.	Have you ever used an inhaler or taken asthma medication?																						

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Athlete \_\_\_\_\_

Signature of parent/guardian \_\_\_\_\_

Date \_\_\_\_\_

**ARCHBISHOP SPALDING HIGH SCHOOL  
PRE-PARTICIPATION PHYSICAL EVALUATION Page 3**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ %Body fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_  
 BP \_\_\_\_/\_\_\_\_ (\_\_\_\_/\_\_\_\_) Vision R 20/\_\_\_\_ L20/\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_ Unequal \_\_\_  
 Risk behaviors discussed: Y N (diet, weight, driving, drugs, alcohol, sexuality, safety, stress)

	Normal	Abnormal Findings	Initials
<b>MEDICAL</b>			
Appearance			
Ears/Eyes/Nose/Throat			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (Males)*			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
*Multiple examiner set-up only. *Having 3 <sup>rd</sup> party present is recommended for genitourinary exam			
Notes			

Please return this form to the Admissions Office by August 1.

Please choose one of the following four (4) options:

1. Cleared without restriction \_\_\_\_\_
2. Cleared, with recommendations for further evaluation or treatment for: \_\_\_\_\_
3. \*Not Cleared, but needs additional evaluation by (whom): \_\_\_\_\_
4. Not Cleared for either \_\_\_ All sports \_\_\_ Certain sports: \_\_\_\_\_

Reason: \_\_\_\_\_

Please note any necessary equipment, medications, or restrictions for cleared athlete to play or practice: By this signature, I hereby state that I have performed a pre-participation examination in accordance with AAPC and AMSSM standards (current edition of Physician and Sports Medicine's Pre-participation Physical Evaluation) and certify that the above clearance and attached PPE is accurate, complete and compliant to such standards. I also agree that I have documented and signed any playing restrictions on **The High School Athlete**.

**Permission to Receive Medication**

\_\_\_\_ Permission is given to the Athletic Training Staff to administer over the counter medications via standing orders from the team physician.

\_\_\_\_ Only Give \_\_\_\_\_ over the counter medication.

\_\_\_\_ Do NOT give any over the counter Medications.

**LIST ANY MEDICATION NOT TO BE GIVEN:** \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

HealthCare Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Title: \_\_\_\_\_ Phone: \_\_\_\_\_

\*If Option 3 above checked then Referred Physician needs to complete below:

\_\_\_\_ Cleared- no restriction \_\_\_\_ Cleared with the following restrictions: \_\_\_\_\_

Not Cleared for \_\_\_ All sports \_\_\_ Certain sports: \_\_\_\_\_

Referred Physician Signature: \_\_\_\_\_

Print: \_\_\_\_\_ Date: \_\_\_\_\_

# SCHOOL ATHLETE MEDICAL CARD

(Parent/Guardian: please print and complete Sections 1, 2 & 3)

**Section 1: Contact/Personal Information**  
Student Name: \_\_\_\_\_ Sport: \_\_\_\_\_ Student ID#: \_\_\_\_\_  
Student Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Guardian's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Student Phone: (H) \_\_\_\_\_ Student Cell \_\_\_\_\_  
Emergency Contact information:  
Mother's Name \_\_\_\_\_ Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Fathers Name \_\_\_\_\_ Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Preference of Physician (and permission to contact if needed):  
Name \_\_\_\_\_ Phone \_\_\_\_\_  
Insurance \_\_\_\_\_ Policy Holders Name \_\_\_\_\_  
Policy No. \_\_\_\_\_ Group/Plan No. \_\_\_\_\_ Phone \_\_\_\_\_

**Section 2: Medical Information**  
Medical Illnesses: \_\_\_\_\_  
Last Tetanus (Mo/Yr): \_\_\_\_\_ Allergies: \_\_\_\_\_  
Prescription Medications: \_\_\_\_\_  
(Any Prescription Medications That May Be Taken During Competition Require A Physician's Note)  
Previous Head/Neck/Back Injury: \_\_\_\_\_  
Previous Heat-Related Problems: \_\_\_\_\_  
Previous Significant Injuries: \_\_\_\_\_  
Any Other Important Medical Information: \_\_\_\_\_

**Section 3: Permission for Medical Transport**  
I give permission for my child to be transported to the nearest emergency room based on local EMS protocols to receive necessary treatment.  
**Permission to Receive and Release Medical Records**  
I understand that Archbishop Spalding High School athletic trainer, the approved health care provider for ASHS, may request information regarding the athlete's health status from a physicians' office, and I hereby give my permission for the receipt and release of this information as it pertains to my child's ability to safely participate in athletics. In addition should treatment be necessary, I give permission for a physician's office to release medical information to allow for the timely treatment of my child by the approved health care provider for ASHS. This request is to facilitate open communication between the athletic trainer and the treating physician in order to optimize patient care. This information cannot and will not be released to other parties without first being approved by the guardian or parent of the athlete. **I understand I will be notified of the necessity of obtaining medical records.**  
Parent/Guardian  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Athlete's  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Section 4: Clearance for Participation**  
\_\_\_\_\_  
Cleared without restrictions \_\_\_\_\_ Cleared with the following restrictions:  
**Health Care Provider's Signature:** \_\_\_\_\_  
**MD/DO, PA, NP Date:** \_\_\_\_\_

For office use only: This card is valid for one calendar year from date of physical. Note: If any changes occur, a new card should be completed by the parent/guardian. The original card should be kept on file in the school athletic director's or athletic trainer's office. A copy or form with similar information should be kept in the sports' athletic kits. This card contains personal medical information and should be treated as confidential by the school, its employees, agents, and contractors.

Name of School: **Archbishop Spalding High School** Name of ATC: **Mr. Thomas J. Morgan**

# Archbishop Spalding High School Athletic Training Dept. Helmet Release Form

Name: \_\_\_\_\_

THIS IS TO CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE WARNING LABEL AS IT APPEARS ON THE OUTSIDE MY HELMET. THE LABEL READS

**FOOTBALL WARNING:**

DO NOT STRIKE AN OPPONENT WITH ANY PART OF THIS HELMET OR FACEMASK. THIS IS A VIOLATION OF FOOTBALL RULES AND MAY CAUSE YOU OR YOUR OPPONENT TO SUFFER SEVERE BRAIN OR NECK INJURY.

SEVERE BRAIN OR NECK INJURY MAY ALSO OCCUR ACCIDENTALLY WHILE PLAYING FOOTBALL OR LACROSSE.

NO HELMET CAN PREVENT ALL SUCH INJURIES. YOU USE THIS HELMET AT YOUR OWN RISK.

**BASEBALL/SOFTBALL HELMET WARNING:**

**WARNING**

DO NOT USE THIS HELMET IF THE SHELL IS CRACKED OR DEFORMED; OR IF THE INTERIOR PADDING IS DETERIORATED. SEVERE HEAD OR NECK INJURY, INCLUDING PARALYSIS OR DEATH MAY OCCUR TO YOU DESPITE USING THIS HELMET. NO HELMET CAN PREVENT ALL HEAD INJURIES OR ANY NECK INJURIES A PLAYER MIGHT RECEIVE WHILE PARTICIPATING IN BASEBALL OR SOFTBALL

**HOCKEY WARNING**

**WARNING**

NO HELMET CAN PREVENT ALL HEAD OR ANY NECK INJURIES A PLAYER MIGHT RECEIVE WHILE PARTICIPATING IN HOCKEY. DO NOT USE THIS HELMET TO BUTT AN OPPOSING PLAYER. THIS IS IN VIOLATION OF THE HOCKEY RULES AND SUCH USE CAN RESULT IN SEVERE HEAD OR NECK INJURIES, PARALYSIS OR DEATH TO YOU AND POSSIBLE INJURY TO YOUR OPPONENT

**LACROSSE WARNING**

DO NOT USE THIS HELMET IF THE SHELL IS CRACKED OR DEFORMED; OR IF THE INTERIOR PADDING IS DETERIORATED. SEVERE HEAD OR NECK INJURY, INCLUDING PARALYSIS OR DEATH MAY OCCUR TO YOU DESPITE USING THIS HELMET. NO HELMET CAN PREVENT ALL HEAD INJURIES OR ANY NECK INJURIES A PLAYER MIGHT RECEIVE WHILE PARTICIPATING IN LACROSSE.

I ALSO UNDERSTAND THAT FOOTBALL AND LACROSSE ARE POTENTIALLY INJURIOUS SPORTS AND AGREE TO ACCEPT THE RISK OF INJURY ASSOCIATED WITH COMPETITION IN THESE SPORTS. NO HELMET CAN PREVENT ALL SUCH INJURIES.

ATHLETE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PARENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PARENT NAME PRINTED: \_\_\_\_\_