

Parent/Student to Complete: HEALTH FORM for NOTRE DAME HIGH SCHOOL

Name: _____ Age: _____ Date of Birth _____

Grade: _____ Sports: _____

Personal Physician: _____ Physician's Phone # _____

Explain "Yes" answers below"

Yes No

- | | | |
|--|--------------------------|--------------------------|
| 1. Have you ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you presently taking any medications or pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any allergies (medicine, bees or other stinging insects)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you tire more quickly than your friends during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever been told that you had a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has anyone in your family died of heart problems or a sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have any skin problems (itching, rashes, acne)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever had a head injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever been knocked out or unconscious? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had a seizure | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had a stinging, burning or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever had heat or muscle cramps? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever been dizzy or passed out in the heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you have trouble breathing or do you cough after your activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guard, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you wear glasses, contacts or protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any of the following bones or joints? Mark all that apply: | | |
| <input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Thigh <input type="checkbox"/> Neck <input type="checkbox"/> Knee <input type="checkbox"/> Chest <input type="checkbox"/> Hip | | |
| <input type="checkbox"/> Forearm <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Foot | | |
| 25. Have you had any other medical problems (infectious mononucleosis, diabetes, etc)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you had a medical problem or injury since your last evaluation? | <input type="checkbox"/> | <input type="checkbox"/> |

Explain "YES" answers:

27. When was your last tetanus shot?.....
28. When was your last measles immunization?
29. When was your last menstrual period?
30. When was your first menstrual period?.....
31. What was the longest time between your periods last year?.....

List any past or current medical conditions _____

List all current prescriptions and meds or supplements _____

List any allergies you have: _____

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

Signature of Athlete: _____ Signature of Parent: _____

Date _____ Date _____

Take this form with you to your physical examination and have the reverse side completed.

PHYSICAL EXAMINATION – NOTRE DAME HIGH SCHOOL

Name: _____ Exam Date: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Vision: Right 20/____ Left 20/____ Corrected ☐ Y ☐ N Pupils: Equal ____ Unequal ____

	Normal	Abnormal Findings	Initials
Medical			
Appearance			
Eyes/Ears/Nose/Throat			
Pulses			
Heart			
Lungs			
Abdomen			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Knee			
Leg/ankle			
Foot			
Other			

CLEARANCE:

- ☐ Cleared to participate in school activities and/or play a high school sport (unrestricted)
- ☐ Cleared after completing evaluation/rehabilitation for: _____
- ☐ Not cleared for _____ Reason: _____

Recommendations: _____

Name of Physician: _____ Date of Exam: _____
(please print clearly)

Address: _____
(Street) (City) (Zip Code)

Physician's Signature: _____, MD or DO Phone: _____

New students- return the completed form to:

Notre Dame High School
455 Palma Drive
Salinas, CA 93901

Returning student playing a sport: Upload to your Home Campus Account



**Physician's Office Stamp
Required**