ATHLETE'S DATE OF BIRTH: ________/________/________ **PRESENT GRADE:** ____________ **CLASS OF:** __________________

NASHOBA REGIONAL SCHOOL DISTRICT DEPARTMENT OF HEALTH SERVICES

PART A: ATHLETIC CANDIDATES MEDICAL QUESTIONNAIRE TO BE COMPLETED BY PARENT / GUARDIAN

STUDENT'S NAME___________________________________ADDRESS__________________________________TOWN/ZIP________________________

PARENT'S NAME____________________________________ADDRESS__________________________________TOWN/ZIP________________________

PHYSICIAN'S NAME__________________________________ADDRESS__________________________________PHONE__________________________

DOES / HAS YOUR CHILD HAVE / HAD A DISEASE (S) THAT AFFECTS THE FUNCTION OF EYE, EAR, TESTICLE, KIDNEY OR LUNG? Y / N

IF SO EXPLAIN____

LIST ANY OPERATIONS, FRACTURES, CONCUSSIONS, SPRAINS OR BONE DISLOCATIONS____

- HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING? CIRCLE Y FOR YES / N FOR NO

ASTHMA	Y	N	MONONUCLEOSIS	Y	N	CHICKEN POX	Y	N
PNEUMONIA	Y	N	HEART MURMUR	Y	N	HEART CONDITION	Y	N
HEPATITIS	Y	N	KIDNEY DISEASE	Y	N	BRONCHITIS	Y	N
HEAT STROKE	Y	N	HEAT EXHAUSTION	Y	N	HEAD INJURY	Y	N
DIABETES	Y	N	CONCUSSION	Y	N	MENSTRUAL PROBLEMS	Y	N
SEIZURES	Y	N	BLOOD DISORDERS	Y	N	ALLERGIES	Y	N
DENTAL PROB.	Y	N	RHEUMATIC FEVER	Y	N	TUMORS	Y	N
FAINTING / DIZZINESS DURING OR AFTER EXERCISE / ACTIVITY				Y	N			

- LIST ANY OTHER INJURY / LLNESS THE HEALTH OFFICE SHOULD BE AWARE OF: ____
- DOES YOUR CHILD TAKE ANY MEDICATIONS NOW? Y / N IF SO WHAT? ____
- DOES YOUR CHILD WEAR GLASSES OR CONTACT LENSES? Y / N
- HAS YOUR CHILD HAD A TETANUS DIPTHERIA BOOSTER WITHIN THE LAST 10 YEARS? Y / N IF SO, DATE _________________________
- DO YOU KNOW OF ANY REASON FOR YOUR CHILD **NOT** TO PARTICIPATE IN ANY ATHLETIC SPORT? Y / N
- THIS IS TO CERTIFY THAT MY SON / DAUGHTER IS COVERED BY EITHER SCHOOL INSURANCE, FAMILY HEALTH INSURANCE, OR FAMILY HEALTH POLICY (CHECK ONE) BC/BS ( ) PRIVATE ( ) HMO ( ) SCHOOL ( ) POLICY #________________________

SIGNATURE OF PARENT / GUARDIAN: ____ **DATE:** _________/________/________

PART B: PHYSICAL EXAMINATION FORM TO BE COMPLETED BY EXAMINING PHYSICIAN

MINIMUM WRESTLING WEIGHT (NEEDED FOR CERTIFICATION): _____________

- AGE______ GRADE_____ HT______ WT______ BP_______/_______
- EYES______ R20/______ L20/______ EARS_______ HEARING R________/15 L________/15
- RESPIRATORY________ CARDIOVASCULAR________ LIVER________MUSCULOSKELETAL________
- NEUROLOGICAL________ GENITALIA________ LAB: URINALYSIS________ OTHER_________________________

COMPLETED IMMUNIZATION DATES:

- POLIO________ TETANUS DIPTHERIA (WITHIN LAST 10 YRS.) ________ MMR 1ST________2ND________VARICELLA_______
- HEPATITIS B VACCINE #1________#2________#3________

THIS A COLLEGE REQUIREMENT FOR ALL HEALTH SCIENCE STUDENTS AS OF 9/1/2000 STARTING W / FRESHMEN TO GRADUATES BY 9/1/2005.

- **THE ABOVE NAMED STUDENT WILL PROVIDE, HAS BEEN TRAINED BY HIS / HER PHYSICIAN TO SELF ADMINISTER AN EPI-PEN, AND WILL CARRY SAME IN CASE OF AN ALLERGIC REACTION TO:** _________________________________ **Y / N**
- **I HAVE ON THIS DATE EXAMINED THIS STUDENT AND ON THE BASIS OF THE EXAMINATION AND MEDICAL HISTORY, I HAVE FOUND NO REASON TO MAKE IT MEDICALLY INADVISABLE FOR THIS STUDENT / ATHLETE TO COMPETE IN SUPERVISED ATHLETIC ACTIVITIES.**
- **EXAMINING PHYSICIAN'S SIGNATURE:** ____
- **DATE OF PHYSICAL EXAM:** ________ / ________ / ________
- **ADDRESS:** ____ **PHONE:** ______________________________
- **THIS STUDENT ATHLETE IS UNABLE TO PARTICIPATE IN ATHLETIC ACTIVITIES UNTIL (DATE):** ________ / ________ / ________
- ***ACCORDING TO M.I.A.A. AND NASHOBA REGIONAL DISTRICT POLICY, THIS PHYSICAL IS VALID FOR (13 MONTHS) OR 395 DAYS FROM THE DATE OF THE EXAMINATION. IT IS RECOMMENDED THAT EXAMINATIONS BE SCHEDULED / PERFORMED IN JULY OR AUGUST PRIOR TO THE START OF THE FALL ATHLETIC SEASON. THIS WILL INSURE MEDICAL CLEARANCE FOR THE ENTIRE SCHOOL YEAR.***

RETURN TO ATHLETIC OFFICE OR HIGH SCHOOL / HEALTH OFFICE. MAKE A COPY FOR YOUR FUTURE USE. **REVISED 6/10/04**