DUDLEY-CHARLTON REGIONAL SCHOOL DISTRICT
Private Physician – Sports Candidate Medical Questionnaire – Part A
Health Examination Form – Part B
M.I.A.A. Recommended

Part A – to be completed and signed by parents/guardian
Part B – to be completed and signed by the examining physician

Student's Name____D.O.B.____________

Parent Name____

Telephone____

Address____

Physician's Name____

Does this student have/had any of the following disease(s):
Please circle Y-yes or N-no.

1. Asthma and/or Allergies	Y N	8. Mononucleosis	Y N
2. Heart Murmur/Heart Condition	Y N	9. Pneumonia or Bronchitis	Y N
3. Kidney Disease or Injury	Y N	10. Hepatitis	Y N
4. Heat Stroke or Heat Exhaustion	Y N	11. Head Injury or Concussion	Y N
5. Diabetes	Y N	12. Seizure or Fainting	Y N
6. Menstrual Problems	Y N	13. Tumors	Y N
7. Blood Disorders	Y N		

Explain any Yes answers to above questions:_________________________________

____

Any other serious injury, hospitalizations or surgeries_________________________

____

Does this student have/had a disease that affects the function of the eye, ear, testicle, kidney or lung?____

____

Does this student take any medications now?_______ If yes, what?_______________

Do you know any reason for your child not to participate in sports?______________

Parent/ Guardian Signature___________________________________ Date________

Return to Nurse

Part B – Sports Physicals to be completed by examining physician annually after July 1st of the school year. Please print.

Student Name_________________________________**I.D.**________**Sport**______________

Grade_______**Age**______**Height**________**Weight**________**Blood Pressure**____________

Significant past illness or injury____

Scoliosis Check____

Respiratory____

Cardiovascular____

Liver__________________________**Spleen**________________**Hernia**_________________

Musculoskeletal__________________________**Skin**_________________________________

Neurological_____________________________**Genitalia**____________________________

Laboratory/Urinalysis______________________**Other**_______________________________

Comments____

Completed Immunizations: Td_______________**MMR 1**____________**MMR 2**_________

Hepatitis B#1________________**#2**___________________**#3**__________________________

Varicella____________________________**TB**____

I have on this date examined this student and on the basis of the examination and the student's medical history, have found no reason which would make it medically inadvisable for this student to compete in supervised athletics.

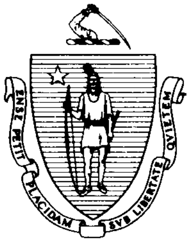
___________________________ ____

Date of Examination **Signature of Examining Physician**

Address___________________________________**Telephone**____________________________

Return to Nurse

Revised 5/2010 DS



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PRE-PARTICIPATION HEAD INJURY/CONCUSSION REPORTING FORM FOR EXTRACURRICULAR ACTIVITIES

This form should be completed by the student's parent(s) or legal guardian(s). It must submitted to the Athletic Director, or official designated by the school, *prior* to the start of each season a student' plans to participate in an extracurricular athletic activity.

Student's Name	Sex	Date of Birth	Grade
School		Sport(s)	
Home Address			Telephone

Has student ever experienced a traumatic head injury (a blow to the head)? Yes________ No________

If yes, when? Dates (month/year): ________________________________

Has student ever received medical attention for a head injury? Yes_______ No_______

If yes, when? Dates (month/year): ________________________________

If yes, please describe the circumstances:

Was student diagnosed with a concussion? Yes_______ No______

If yes, when? Dates (month/year): ________________________________

Duration of Symptoms (such as *headache, difficulty concentrating, fatigue*) for most recent concussion: _______________

Parent/Guardian:
Name: _________________________________Signature/Date ___________________________________
(Please print)

Student Athlete:
Signature/Date ____