

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** _____

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 _____