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 _____ **DOB** _____

Parent Name _____

Telephone _____

Address _____

Physician's Name _____

Does this student have/had any of the following disease(s): Please indicate 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_____

Revised 5/2010 DS