

**Mater Dei Catholic School
Pre-Participation Physical Evaluation**

To be completed annually by every participant and parent or guardian:

Name: _____ Sex: _____ Date of birth: _____

Grade: _____ School: _____ Sport(s): _____

Parent(s)/Guardian(s): _____

Home Address: _____ Telephone: _____

Record date of most recent immunizations for Td _____ for DPT _____

PARENT/GUARDIAN NEEDS TO COMPLETE QUESTIONS ON FIRST THREE PAGES.

Prior to examination by physician, student/parent/guardian needs to answer the following questions by writing yes or no. Explain, "yes" answers in the blank space on the next page. Circle the number of questions when the answer is unknown.

- _____ 1. Have you had a medical illness or injury since your last check up or sports physical?
_____ Do you have an ongoing or chronic illness?
- _____ 2. Have you ever been hospitalized overnight?
_____ Have you ever had surgery?
- _____ 3. Are you currently taking a prescription or non-prescription medications or pills or using an inhaler?
_____ Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?
- _____ 4. Do you have any allergies? Have you ever had a rash or hives develop during or after exercise?
- _____ 5. Have you ever passed out during or after exercise?
_____ Have you ever been dizzy during or after exercise?
_____ Have you ever had chest pain during or after exercise?
_____ Do you get tired more quickly than your friends do during exercise?
_____ Have you ever had racing of your heart or skipped heartbeats?
_____ Have you had high blood pressure or high cholesterol?
_____ Have you ever been told you have a heart murmur?
_____ Has any family member or relative died of heart problems or of sudden death before age 50?
_____ Have you had a severe viral infection (example: myocarditis or mononucleosis) within the last month?
_____ Has a physician ever denied or restricted your participation in sports for any heart problems?
- _____ 6. Do you have any current skin problems (example: itching, rashes, acne, warts, fungus, or blisters)?
- _____ 7. Have you ever had a head injury or concussion? Date: _____ How Many: _____
_____ Have you ever been knocked out, become unconscious, or lost your memory?
_____ Have you ever had a seizure?
_____ Have you ever had numbness or tingling in your arms, hands, legs, or feet?
_____ Have you ever had a stinger, burner, or pinched nerve?
- _____ 8. Have you ever become ill from exercising in the heat?
- _____ 9. Do you cough, wheeze, or have trouble breathing during or after activity?
_____ Do you have asthma?
_____ Do you have seasonal allergies that require medical treatment?
- _____ 10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (example: knee brace, foot orthotics, retainer on you teeth, hearing aid)?
- _____ 11. Have you had any problems with your eyes or vision?
_____ Do you wear glasses, contacts, or protective eyewear?
- _____ 12. Have you ever had a sprain, fracture or dislocation of a muscle, tendon, bone or joint? If yes, underline the appropriate word(s) underlined and then explain in the space provided at the end of this section:
head neck back chest shoulder upper arm elbow forearm wrist hand finger hip thigh
knee shin/calf ankle foot

Females Only

- _____ 13. Have you begun menstruation?
_____ If yes, are you ever experiencing any problem (example: irregularity, pain)?

Consent for Treatment

WE) (I), _____, the parent(s) and/or legal guardian(s) of _____ consent to and authorize, for the _____ school year, any representative of Mater Dei Catholic School to authorize medical treatment, including any necessary surgery or hospitalization, on (OUR) (MY) above named dependent, for any injury or illness of an emergency nature (HE) (SHE) will incur while at Mater Dei Catholic School by any physician and dentist licensed in accordance with the provisions of the Kansas Healing Arts Act, Kansas Statutes Annotated 65-2801 and any hospital.

(WE) (I) agree to pay and assume all responsibility for all medical and hospital expenses and any services of any emergency nature, and charges for (OUR) (MY) dependent.

(WE) (I) acknowledge and agree that Mater Dei Catholic School, Mater Dei Parish, and the Archdiocese of Kansas City in Kansas are not responsible for any medical and hospital expenses and charges that are incurred in the medical treatment or hospitalization of (OUR) (MY) dependent.

A photocopy of this Consent For Treatment document shall have the same force and effect as the original.

By signing below we agree and will abide by all things asked of us in the preceding pages of the physical evaluation.

Parent or Guardian's Signature: _____ Date: _____

Parent or Guardian's Signature: _____ Date: _____

Student's Signature: _____ Date: _____

FREE SPORTS PHYSICAL

If a child wishes to participate in the TPL sports programs, that child must have a physical assessment completed by a physician or nurse practitioner and a copy of that assessment must be on file at Mater Dei School. These physical must be completed each school year. Mater Dei does invite a licensed physician each give to do this assessments, at no cost to the parent. This year _____ will do our assessments on _____.

If you wish for your child to be included for these assessments please complete the following and make sure this sheet is at school on the date listed above:

As parent/legal guardian of _____, I hereby give consent for a physical assessment to be performed on the above-named child/minor by _____ on _____. Such physical assessment will be performed at Mater Dei Catholic School.

Parent or Guardian's Signature: _____ Date: _____

Parent or Guardian's Printed Name: _____

Physical Assessment Consent

As parent/legal guardian _____, I hereby give consent for a physical assessment to be performed on the above-named child/minor by _____ on _____ on _____. Such physical will be performed at Mater Dei School.

Signature of Prent/Guardian _____ Date _____

Printed Name of Parent/Guardian _____

If questions please contact: Sarah Burenhide, Mater Dei School Nurse.

By phone: 233-1727. By email: msburenheide@yahoo.com

To be completed and signed by the physician or nurse practitioner:

Name: _____ Date of birth: _____

Height: _____ Weight: _____ Tanner Stage: I II III IV V Pulse: _____ Blood Pressure: _____

Vision: R 20/ _____ L 20/ _____ Corrected: Yes No Pupils: Equal Unequal

Record date of most recent immunizations for Td _____ for DPT _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia/Hernia			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Cleared for all activities

Not cleared for: _____

Reason: _____

Recommendation: _____

I hereby certify that I am qualified by training and experience to properly perform the examination and make the evaluation reflected on this form:

Name of physician (print/type) _____ Date: _____

Address (Street/City/State/Zip) _____ Telephone: _____

Signature of physician _____ MD, DO, DC, OR RPA _____