St. John Paul II Catholic School
MEDICAL EXAMINATION FORM*

Date: _____

Student: _____ **Grade:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Parent/Guardian: _____ **Phone:** _____

Emergency Cell: _____ **Phone:** _____

Family Physician: _____ **Phone:** _____

The student's parent(s) or guardian(s) grant permission for their middle school student to participate in the following interscholastic sports: _____

Medical History
(To be completed by parents)

Student: _____ **DOB:** _____ **Age:** _____

Place a check in the appropriate column that best answers the question. If "Yes" is the answer, please provide details in the space provided below the table.	**Yes** **	**No**	**Don't know**
1.) Has the athlete ever stopped exercising because of dizziness or passed out during exercise?			
2.) Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise?			
3.) Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint?			
4.) Does the athlete have a history or concussion (getting knocked out)?			
5.) Has the athlete ever suffered a heat-related illness (heat stroke)?			
6.) Does the athlete have a chronic illness or see a doctor regularly for any particular problem?			
7.) Does the athlete take any medication(s)?			
8.) Is the athlete allergic to any medications, food, clothing, bee stings, etc.?			
9.) Does the athlete have only one of any paired organ (eyes, ears, kidneys, testicles, ovaries, etc.)?			
10.) Has the athlete had an injury in the last year that caused him/her to miss 3 or more days of practice or competition?			
11.) Has the athlete had surgery or been hospitalized in the past year?			
13.) Does the athlete wear glasses, contacts, or a dental appliance?			
**Please give details on any "Yes" answers			