



Physical Examination Form

St. David's School Year 2011-2012

NOTE TO PARENT: St. David's School requires a current Physical Examination Form for all new students. The exam must be completed within 12 months prior to the start of the school year. **All students trying out or participating in the interscholastic athletic program must have an ANNUAL physical. A physical examination after April 1 will be sufficient for all athletic activities throughout the school year. Exam expires after 12 months.**

Name _____ Date of Birth _____ Age _____ Gender _____

Grade _____ Parent/Guardian _____

Health History - *To be completed by parent*

Allergies (medication, food, insect sting) _____

Please check any of the following illnesses or behavioral difficulties the student has or has had:

- | | | |
|---|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Bowel Problems |
| <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Dental Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Headaches(chronic) | <input type="checkbox"/> Bone/muscle Problems |

Explain as needed: _____

Current Medications: _____

Athletic Medical History - *To be completed by parents of 7th-12th grade students wishing to participate in Interscholastic Athletics*

- | | | | |
|--|---------|----|------------|
| 1. Has anyone in the athlete's extended family died suddenly before age 50? | 1. YES | NO | DON'T KNOW |
| 2. Has the athlete ever stopped exercising because of dizziness or passed out during exercise? | 2. YES | NO | DON'T KNOW |
| 3. Does the athlete ever have asthma, hay fever or coughing spells after exercise? | 3. YES | NO | DON'T KNOW |
| 4. Has the athlete ever had a broken bone, or had an injury to any joint? | 4. YES | NO | DON'T KNOW |
| 5. Does the athlete have a history of a concussion (getting knocked out)? | 5. YES | NO | DON'T KNOW |
| 6. Has the athlete ever suffered a heat related illness (heat stroke)? | 6. YES | NO | DON'T KNOW |
| 7. Does the athlete have only one of any paired organ? (eyes, kidneys, ovaries, etc.) | 7. YES | NO | DON'T KNOW |
| 8. Has the athlete had an injury in the last year that caused the athlete to miss three or more consecutive days of competition? | 8. YES | NO | DON'T KNOW |
| 9. Has the athlete had surgery or been hospitalized in the past year? | 9. YES | NO | DON'T KNOW |
| 10. Has the athlete missed more than five consecutive days of participation in usual activities because of an illness, or has the athlete had a medical illness diagnosed that has not been resolved in the past year? | 10. YES | NO | DON'T KNOW |
| 11. Are you, the athlete, worried about any problem or condition at this time? | 11. YES | NO | DON'T KNOW |

Please give details on any "YES" answer from the above history.

Name _____ Date of Birth _____

Immunization History

DTP/DTAP _____

OPV/IPV _____

DT/TD _____

HIB _____

MMR _____

VARICELLA _____

HEPATITIS A _____

HEPATITIS B _____

HPV _____

TB SKIN TEST (at physician discretion) Date: _____ Result: _____

Physical Exam – *To be completed by physician after review of history.*

Weight _____ Height _____ BP _____ Pulse _____ Urinalysis _____

Hgb./Hct _____ Vision: Rt _____ Lt: _____ Hearing: Rt _____ Lt _____

Vision or Hearing referral needed _____

Review of Systems: (Check if normal. Note abnormal findings below.)

___ Skin/nodes ___ Head/Neck ___ E.E.N.T. ___ Cardiovascular

___ Chest/Lungs ___ Genital/Urinary ___ Musculoskeletal ___ Neurological

Abnormal findings _____

Current treatment for emotional or psychological problems? _____

Is this student able to participate in Physical Education? _____

Comments: _____

Is this student cleared to participate in all Athletics? _____

Exceptions: _____

Physician Signature _____ Date of exam _____

Please Print/Stamp:

Physician's Name _____

Street Address _____

City, State, Zip Code _____

Telephone _____

Return by August 2 to:

ST. DAVID'S SCHOOL
 Attention: Nurse
 3400 White Oak Road
 Raleigh, NC 27609

or Fax to: (919) 782-3689