# Saint Saviour High School

588 Sixth Street • Brooklyn • New York 11215 Telephone: (718) 768-4406

*educating the young women of Brooklyn since 1917*

## INTERSCHOLASTIC • SPORTS EXAMINATION

**NAME:** **DATE OF BIRTH:**

**STUDENT'S MEDICAL HISTORY:** (to be filled out by parent/guardian) **Explain all 'Yes' answers below**

Has anyone in your family under age 45 died suddenly? . . . **Yes** ❑ **No** ❑
Have you ever been hospitalized . . . **Yes** ❑ **No** ❑
Have you ever had surgery? . . . **Yes** ❑ **No** ❑
Do you take any medicines? . . . **Yes** ❑ **No** ❑
Do you smoke? . . . **Yes** ❑ **No** ❑
Do you have Asthma? . . . **Yes** ❑ **No** ❑
Do you have trouble breathing during or after exercising or activities: . . . **Yes** ❑ **No** ❑
Do you have Diabetes? . . . **Yes** ❑ **No** ❑

**Have you ever:**
had a concussion or been knocked out? . . . **Yes** ❑ **No** ❑
been dizzy or fainted from exercising? . . . **Yes** ❑ **No** ❑
suffered from heat stroke or muscle cramps? . . . **Yes** ❑ **No** ❑
had an Epileptic seizure? . . . **Yes** ❑ **No** ❑
had a head or neck injury? . . . **Yes** ❑ **No** ❑
had vision problems in one or both eyes? . . . **Yes** ❑ **No** ❑
Do you wear glasses, contacts, or protective eyewear? . . . **Yes** ❑ **No** ❑
had a hearing loss or deafness? . . . **Yes** ❑ **No** ❑
had a perforated ear drum or "tubes" in ears? . . . **Yes** ❑ **No** ❑
had draining ears? . . . **Yes** ❑ **No** ❑
had sinus problems or hay fever? . . . **Yes** ❑ **No** ❑
had braces or removable false teeth? . . . **Yes** ❑ **No** ❑
Do you need to wear a mouth guard? . . . **Yes** ❑ **No** ❑
had a broken bone? _____ . . . **Yes** ❑ **No** ❑
had a dislocation or other serious joint problem? . . . **Yes** ❑ **No** ❑
had an ankle or knee injury? . . . **Yes** ❑ **No** ❑
Do you need pads or braces while playing? . . . **Yes** ❑ **No** ❑
had a serious foot problem: . . . **Yes** ❑ **No** ❑
had other joint problems? . . . **Yes** ❑ **No** ❑
had a back injury or frequent backaches? . . . **Yes** ❑ **No** ❑
had a stinging, burning or pinched nerve? . . . **Yes** ❑ **No** ❑
Do you have a hernia? . . . **Yes** ❑ **No** ❑
had any menstrual problems? . . . **Yes** ❑ **No** ❑
Age at first menstrual period? _____
Do you miss school because of your period? . . . **Yes** ❑ **No** ❑
had a single illness for more than 10 days? . . . **Yes** ❑ **No** ❑
had infectious Mononucleosis . . . **Yes** ❑ **No** ❑
been anemic, had easy bruising or bleeding tendencies? . **Yes** ❑ **No** ❑
had allergies from bee stings, food or medicine, etc? . . . **Yes** ❑ **No** ❑
had a cough lasting more than 3 weeks? . . . **Yes** ❑ **No** ❑
had heart trouble or murmurs? . . . **Yes** ❑ **No** ❑
had high blood pressure? . . . **Yes** ❑ **No** ❑
had chest pain during or after exercising? . . . **Yes** ❑ **No** ❑
had kidney problems? . . . **Yes** ❑ **No** ❑
had skin problems (itching, rashes or acne)? . . . **Yes** ❑ **No** ❑

Have you ever been told not to play any sport because of your health? . . . **Yes** ❑ **No** ❑

Have you had any medical problems or injuries since your last evaluation? . . . **Yes** ❑ **No** ❑

**I hereby state that, to the best of my knowledge, my answers to the above questions are correct.**

**PARENT/GUARDIAN SIGNATURE** **DATE**

**STUDENTS NAME:** **DATE OF LAST TETANUS SHOT:**

**PHYSICAL EXAMINATION:** A complete physical examination for all students is required.

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____

Vision Uncorrected: L20/ _____ R20/ _____ Corrected: L20/ _____ R20/ _____

| | Normal/Abnormal | Clinician's Comments |
|---|---|---|
| Skin | Norm ❑ Abn ❑ | |
| Eyes | Norm ❑ Abn ❑ | |
| ENT | Norm ❑ Abn ❑ | |
| Mouth & Teeth | Norm ❑ Abn ❑ | |
| Neck | Norm ❑ Abn ❑ | |
| Cardiovascular | Norm ❑ Abn ❑ | |
| Lungs, Chest | Norm ❑ Abn ❑ | |
| Spine | Norm ❑ Abn ❑ | |
| Abdomen | Norm ❑ Abn ❑ | |
| Genitalia (Hernia) | Norm ❑ Abn ❑ | |
| Maturation Index | Norm ❑ Abn ❑ | |
| **Extremities:** | | |
| Orthopedic | Norm ❑ Abn ❑ | |
| Neuromuscular | Norm ❑ Abn ❑ | |

**ASSESSMENT:**

**PLAN:**

**PHYSICIANS EXAMINATION MUST BE DATED AFTER JUNE 1st**

This certifies that I have examined the above named student and she is in good health and is physically cleared to participate in all interscholastic sports without restrictions during the school year.

**Date of Examination** _____

**Print name of Physician** _____

**Physicians Signature** _____

**Registry #**

**Physicians Stamp**