

# Christian Brothers Academy – Annual Physical Evaluation History Form – to be completed by parent prior to seeing the Doctor.

(Note: please fill out using pen and sign at the bottom of all pages. The physician should keep a copy of this form in the chart.)

Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_ Phone (home) \_\_\_\_\_ (mobile) \_\_\_\_\_

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

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Do you have any allergies?      ... Yes ... No If yes, please identify specific allergy below.  
 Medicines                                  ... Pollens                                  ... Food                                   Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify below: ... Asthma ... Anemia ... Diabetes ... Infections Other: _			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure      ... A heart murmur <input type="checkbox"/> High cholesterol            ... A heart infection <input type="checkbox"/> Kawasaki disease            Other: _			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?		
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?			40. Have you ever become ill while exercising in the heat?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have sickle cell trait or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Have you had any problems with your eyes or vision?		
			44. Have you had any eye injuries?		
			45. Do you wear glasses or contact lenses?		
			46. Do you wear protective eyewear, such as goggles or a face shield?		
			47. Do you worry about your weight?		
			48. Are you trying to or has anyone recommended that you gain or lose weight?		
			49. Are you on a special diet or do you avoid certain types of foods?		
			50. Have you ever had an eating disorder?		
			51. Do you have any concerns that you would like to discuss with a doctor?		
BONE AND JOINT QUESTIONS	Yes	No	Explain "yes" answers here		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			_____		
18. Have you ever had any broken or fractured bones or dislocated joints?			_____		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			_____		
20. Have you ever had a stress fracture?			_____		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)			_____		
22. Do you regularly use a brace, orthotics, or other assistive device?			_____		
23. Do you have a bone, muscle, or joint injury that bothers you?			_____		
24. Do any of your joints become painful, swollen, feel warm, or look red?			_____		
25. Do you have any history of juvenile arthritis or connective tissue disease?			_____		

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

Signature of Student \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

# Christian Brothers Academy – Annual Physical Evaluation

## Students with Special Needs:

### Supplemental History– to be completed by parent prior to seeing the Doctor.

(Note: please fill out using pen and sign at the bottom of all pages. The physician should keep a copy of this form in the chart.)

Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

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Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

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

Signature of Student \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

# Christian Brothers Academy – Annual Physical Evaluation

## PHYSICAL EXAMINATION FORM

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**PHYSICIAN REMINDERS**

1. Consider additional questions on more sensitive issues
  - Do you feel stressed out or under a lot of pressure?
  - Do you ever feel sad, hopeless, depressed, or anxious?
  - Do you feel safe at your home or residence?
  - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
  - During the past 30 days, did you use chewing tobacco, snuff, or dip?
  - Do you drink alcohol or use any other drugs?
  - Have you ever taken anabolic steroids or used any other performance supplement?
  - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
  - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION			
Height	Weight	... Male	... Female
BP	/ ( / )	Pulse	Vision R 20/ L 20/ Corrected ... Y ... N
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			
Eyes/ears/nose/throat • Pupils equal • Hearing			
Lymph nodes			
Heart <sup>a</sup> • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only) <sup>b</sup>			
Skin • HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic <sup>c</sup>			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional • Duck-walk, single leg hop			

<sup>a</sup>Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.  
<sup>b</sup>Consider GU exam if in private setting. Having third party present is recommended.  
<sup>c</sup>Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

Cleared for physical education and all sports without restriction  
 Cleared for physical education and all sports without restriction with recommendations for further evaluation or treatment for \_\_\_\_\_  
 \_\_\_\_\_  
 Not cleared

Pending further evaluation  
 For physical education or any sports  
 For certain physical education activities or certain sports \_\_\_\_\_  
 Reason \_\_\_\_\_  
 Recommendations \_\_\_\_\_  
 \_\_\_\_\_

I have examined the above-named student and completed the physical evaluation. The student does not present apparent clinical contraindications to participate in physical education and/or sport(s) as outlined above. A copy of the entire physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the student has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the student and parents/guardians.

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Signature of physician \_\_\_\_\_

# Christian Brothers Academy – Annual Physical CLEARANCE FORM

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

Cleared for physical education and all sports without restriction

Cleared for physical education and all sports without restriction with recommendations for further evaluation or treatment for \_\_\_\_\_

Not cleared

Pending further evaluation

For physical education or any sports

For certain Physical education activities or certain sports \_\_\_\_\_

Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

## EMERGENCY INFORMATION

Allergies \_\_\_\_\_

Other information \_\_\_\_\_

I have examined the above-named student and completed the physical evaluation. The student does not present apparent clinical contraindications to participate in physical education and/or sport(s) as outlined above. A copy of the entire physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the student has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the student and parents/guardians.

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_

## Completed Cardiac Assessment Professional Development Module

Date \_\_\_\_\_ Signature \_\_\_\_\_