



**ST ROBERT BELLARMIN CYO PHYSICAL EXAMINATION FORM**

Please answer all questions thoroughly. This information is important for your child's safety. All information will be kept confidential unless needed in an emergency situation. The Health History portion must be signed by a licensed physician or nurse practitioner.

Name: \_\_\_\_\_ Phone: (\_\_\_\_) - \_\_\_\_\_

Address (Street, City, Zip) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

**HEALTH HISTORY INFORMATION**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Have you experienced any of the following: (Please provide dates on space provided)

Allergy to Bee Stings	Developmental Disability	Hernia
Allergy to Medication	Diabetes	Hypertension
Arthritis	Ear Infection	Lung Disease
Back Injury	Epilepsy	Kidney Problems
Balance Problems	Fainting Spells	Rheumatic Fever
Bladder Control Problems	Frequent Colds	Seizures
Bronchitis	Head Injury	Sleep Walking
Chicken Pox	Heart Disease/Defect	Stomach Upsets
Constipation	Hemophilia	Stroke
Other	Other	Other

If you check any of the above, please explain: \_\_\_\_\_

\_\_\_\_\_

Do you have any sensory, physical, or cognitive disabilities? Yes \_\_\_ No \_\_\_ If yes, explain: \_\_\_\_\_

\_\_\_\_\_

Do you have any mobility impairment? Yes \_\_\_ No \_\_\_ If yes, explain: \_\_\_\_\_

\_\_\_\_\_

Is there evidence of a hernia? Yes \_\_\_ No \_\_\_ If yes, would athletic competition be injurious? \_\_\_\_\_

Heart Condition: ( circle one ) Satisfactory Unsatisfactory Lung Condition: (circle one ) Satisfactory Unsatisfactory

Is the general condition of the eyes, ears, feet, mouth, and nose satisfactory? Yes \_\_\_ No \_\_\_ If no, explain: \_\_\_\_\_

\_\_\_\_\_

Other Allergic Reactions? \_\_\_\_\_

Any Dietary Restrictions? \_\_\_\_\_

Has the participant been treated or hospitalized in the last 24 months? If yes, for what injury or illness? \_\_\_\_\_

\_\_\_\_\_

Participating Sports: Soccer \_\_\_ Volleyball \_\_\_ Basketball \_\_\_ Baseball \_\_\_ Softball \_\_\_ Track \_\_\_

I certify that on this day of \_\_\_\_\_, I have examined the above individual and recommend HIM/HER as physically able to compete in all the supervised athletic activities listed above except for: \_\_\_\_\_

Signature of Examining Physician/Practitioner: \_\_\_\_\_ Phone: (\_\_\_\_) - \_\_\_\_\_