

Brophy College Preparatory Physical Examination Form

Student's Name: _____ Graduation Year: _____ Birthdate: _____

Last
First
Initial

Section 1: To be filled out and signed by examining physician/examiner

*Please cite abnormal findings
 *Please see 2nd page orth. screen

Height (inches): _____ Weight: _____ Blood Pressure: _____ / _____ (_____ / _____, _____ / _____) Pulse(s): _____
 Glasses: _____ Contacts: _____ (Wearing _____) Vision: Right : 20/ _____ Left: 20/ _____ Pupils: Equal _____ Unequal _____ Body Fat %: _____
 Ears/Nose/Throat: _____ Lungs: _____
 Lymph Nodes: _____ Skin: _____ Heart: _____
 Abdomen: _____ Hernia: _____ Testicles: _____
 Deformities or present illness or other concern: _____

*I certify that I have examined the above student and I feel this individual may participate in all scholastic and interscholastic physical activities, except the following: _____

 Name of examining physician (print please) Physician's address Phone

 Signature of examining physician Date

Section 2: Health history: *Extremely important that this information is accurate. To be filled out and signed by parent/guardian, with son's input. Please circle yes or no and write details/dates if "yes", then sign.

1. Has your son ever been hospitalized, had surgery, or had any chronic illness? YES NO Details: _____
2. Is your son currently taking medication? Which? Dosage?..... YES NO Details: _____
3. Does your son have any allergies? Any severe?..... YES NO Details: _____
4. Does your son have any skin problems, rashes? Any during/after exercise? YES NO Details: _____
5. Does your son have vision problems? Contacts/Glasses? YES NO Details: _____
6. Has your son ever passed out during exercise? YES NO Details: _____
7. Has your son ever been dizzy during or after exercise? YES NO Details: _____
8. Has your son had any chest pain during or after exercise? YES NO Details: _____
9. Does your son tire more quickly than his peers during exercise? YES NO Details: _____
10. Has your son ever had high blood pressure or high cholesterol? YES NO Details: _____
11. Has your son ever been told he has a heart murmur? YES NO Details: _____
12. Has your son ever had a racing of the heart or skipped beat? YES NO Details: _____
13. Has a family member died of heart problems or sudden death before 50? YES NO Details: _____
14. Has your son ever had rheumatic fever? YES NO Details: _____
15. Does your son have a cough or trouble breathing during exercise?
 Has he ever been diagnosed with asthma/use inhaler/meds? Which? YES NO Details: _____
16. Has your son ever had heat cramps, heat illness, or heat stroke during
 or after exercise, or is he prone to heat illness? YES NO Details: _____
17. Has your son ever had a concussion, head injury, or frequent headaches?
 Has he ever lost memory, been knocked out, or been unconscious? YES NO Details: _____
18. Is your son missing a paired organ? YES NO Details: _____
19. Does your son get chronic sore throats or have sinus problems? YES NO Details: _____
20. Does your son have a hearing deficiency? YES NO Details: _____
21. Has your son ever had TB, Valley fever, hepatitis, or any infectious/viral
 disease? Any recent (esp myocarditis, mononucleosis, etc)? YES NO Details: _____
22. Has your son ever experienced a seizure? Any recent seizures? YES NO Details: _____
23. Does your son use any prescription or non-prescription dietary supplement to
 gain or lose weight or improve sport performance? YES NO Details: _____
24. **Has your son had any medical problems since his last evaluation, or
 ever been denied /restricted participation in sports for any reason?** YES NO Details: _____
25. **Is there any other medical concern that the BCP medical care providers
 should know, or any restrictions on your son in athletic participation?** YES NO Details: _____

Most recent shot date for: Tetanus: _____ Measles immuniz.: _____ Hep. B: _____ Chicken Pox: _____

***I hereby state that the above information is true, to the best of my knowledge, and will report any changes in this information to the school's health care providers.**

_____ (Parent/guardian signature) _____ (Student signature) _____ (Date)

Section 3: Emergency Information/Consent: To be filled out and signed by parent/guardian:

***Please report any changes in information to Brophy's athletic trainer and the principal's office**

Student's Name: _____

Father's Name: _____ Mother's Name: _____ Guardian's Name: _____

Home Address: _____ City: _____ Zip Code: _____

Home Phone: (_____) _____ Father day phone: (_____) _____ Mother day phone: (_____) _____

Parent(s) E-mail Address: _____

Insurance Company: _____ Policy Number: _____

In an emergency, if parents cannot be contacted, notify:

1) _____ Phone: (_____) _____

2) _____ Phone: (_____) _____

Family Physician: _____ Office phone: (_____) _____ Preferred Hospital: _____

Mandatory Informed Consent Information

I/We, hereby, give consent for the designated school personnel, athletic trainer, team physician, or coach to issue first aid, to use his/her judgment in activating the emergency medical system, and we hereby grant permission for the athletic trainer to treat my son.
(check one) YES NO

My son is able to participate in physical education class and/or intramurals. YES NO

The following are sports or activities in which we do not wish our child to participate: _____

I/We give our son _____ permission to participate in interscholastic athletics, physical education, and/or intramurals. I/We realize such activity involves potential for injury, which is inherent in all sports and activities. I understand there is a meeting where specific risks will be presented. I/we understand that if I/we have questions pertaining to this risk, I/we will address them to the coach, athletic director, or athletic trainer. I/We realize that even with the best coaching, use of the most advanced protective equipment, and strict observance of rules, injuries are still a possibility. I/we understand that these injuries range from minor to severe: on rare occasions, the injuries may be so severe as to result in total disability, paralysis, quadriplegia, or even death. I/We understand and acknowledge these risks. I/we understand the specific risks associated with the sport or activities in which my son will participate, and I/we have read and understand this warning. I/We also understand we can contact school medical personnel if I/we have further questions or concerns. I/We agree to contact the athletic trainer or other school medical personnel if there are any changes to my son's health, if pertinent information needs to be communicated for appropriate medical care, or if there are any limitations to my son's activities. I/we accept the risks as a condition of my son's participation in sports or activities.

(Parent/Guardian signature)

(Date)

***A parent/guardian is required to attend one informed consent meeting and sign a consent statement. Annually, a parent/guardian must sign the consent statement above.**

Important School Information: Please note the following phone numbers, etc. and copy/record:

School Address: Brophy College Preparatory
4701 N. Central Ave.
Phoenix, AZ 85012

School Phone: (602)264-5291 Athletic Dir: x6224 jchambers@brophyprep.org
Athletic Trainer: x6271 cwhite@brophyprep.org
Team Physician: Dr. Michael Lee (72)

School Fax: (602)234-1669

School E-Mail: www.brophyprep.org

AZ Orthopedic & Sports Med Specialists
2222 E. Highland Ave.
Phoenix, AZ 85016
(602)667-6640

Brophy College Preparatory: Athletic Injury History & Orthopedic Screen

*Mandatory for All Sport Participants

Section 1: To be filled out and signed by parent/guardian, with son's input, before examination

I hereby affirm the following information to be true, to the best of my knowledge, and I authorize examination of my son.

(parent/guardian signature)

(date)

*Please circle YES or NO: if YES, specify body part, right or left, nature of injury (sprain, fracture, etc), and date of occurrence.

Has your son experienced any of the following?

1. Concussion, head injury, unconsciousness, or seizures: **YES** **NO** If yes, explain w. dates: _____
2. Neck injury, pain, problems: **YES** **NO** If yes, any radiating pain/burning/numbness, associated weakness in shoulder, or hand? _____
3. Upper or lower back pain/problems: **YES** **NO** If yes, any radiating pain/burning/numbness into back, buttocks, or legs? _____
4. Trunk or abdominal problems/injury or internal injury: **YES** **NO** If yes, explain: _____
5. Hip injury/problem: **YES** **NO** If yes, explain: _____
6. Knee injury/problem: **YES** **NO** If yes, explain: _____
7. Lower leg, ankle, foot, toes injury/problem: **YES** **NO** If yes, explain: _____
8. Shoulder or elbow injury/problem: **YES** **NO** If yes, explain: _____
9. Arm, wrist, hand, finger, thumb injury/problem: **YES** **NO** If yes, explain: _____
10. Does your son wear, or require, any special protective equipment (eyewear, brace, etc.): **YES** **NO** If yes, explain: _____
11. Has your son had any other injury, surgery, or problem that warranted medical attention, or which requires special attention, limitations, or instructions for safe participation? **YES** **NO** If yes, please explain: _____
12. Do you feel there should be any limits to your son's participation in activities because of symptoms of illness, injury, or other concerns known to you or your family physician? **YES** **NO** If yes, explain: _____

Section 2: To be filled out by examiner, and signed by physician

Please assess the following areas: indicate "WNL" if w/in normal limits, or indicate if there is weakness, tightness, or instability, etc. Describe the specific deficiency or positive test in the space provided, and check appropriate recommendation on right, sign & date.

MUSCLE TIGHTNESS/WEAKNESS:

- | | |
|----------------------------------|--------------------------------|
| ____ Heel cord (Gastroc/Soleus): | ____ Shoulder: |
| ____ Hamstrings: | ____ Neck: |
| ____ Quadriceps: | ____ Posture (Scoliosis, etc): |
| ____ Hip muscles: | ____ Other: _____ |
| ____ Back: | |

JOINT INSTABILITY/ETC:

- | | |
|----------------------|----------------------------|
| ____ Ankle: | ____ Shoulder: (direction) |
| ____ Knee: | ____ Other: |
| ____ Patellofemoral: | |

CHECK ONE (Physician)

- ____ Cleared to participate: no restrictions or limit.
- ____ Cleared to participate w/ following recomm.:

- ____ No participation until the following is done:

- ____ No participation for following reason: _____

*

(Physician's signature)

(date)

Brophy Athletics Emergency Card

Athlete Name: _____ Yr of Grad: _____
 Birthdate: _____

Insurance Information (Student must have insurance to participate):
 Company: _____ Policy/Group Number: _____

Contact Info:
 Hm phone father: _____ Wk phone father: _____
 Hm phone mother: _____ Wk phone mother: _____
 Cell: _____ Email: _____

*If parent/guardian not available, contact:
 1) _____ Relationship: _____ Phone: _____
 2) _____ Relationship: _____ Phone: _____
 Family Dr: _____ Phone: _____ Pref. Hospital: _____

Student Health History

	Yes	No	Details (use back if needed)
1. Allergies (bee, etc: severe?)			
2. Heart Condition			
3. Asthma/Respir. Problems			
4. Medications			
5. Medical Condition or Special Concern			

Consent for Emergency Care:

Be it known that if I cannot be reached, I, the undersigned, do hereby give consent to any medical doctor/hospital to render aide, treatment, or care to said student, on an emergency basis, in the event that said student should be injured or stricken ill while participating in an activity sponsored by the above named school. It is further understood that any expense incurred will be paid for by insurance or the parent of the student. Payment of expense is not a school responsibility.

___ **YES I give my consent** ___ **NO I do not give my consent**

Parent signature: _____ **Date:** _____