



# BROPHY COLLEGE PREPARATORY PHYSICAL EXAMINATION FORM

**Student Name:** \_\_\_\_\_ **Graduation Year:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
Last First Initial  
**Home Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_  
**Father's Name:** \_\_\_\_\_ **Mother's Name:** \_\_\_\_\_ **Guardian:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_ **Father day phone:** \_\_\_\_\_ **Mother day phone:** \_\_\_\_\_  
**Email Address 1:** \_\_\_\_\_ **Email Address 2:** \_\_\_\_\_

## SECTION 1: MANDATORY INFORMED CONSENT (PARENT/STUDENT COMPLETES)

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/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. I acknowledge that the all information on this physical form is accurate and I will report any changes to Brophy's health care providers. In the event that I cannot be reached, I, the undersigned parent/guardian of the student above named, do hereby give and grant unto any medical doctor, hospital, or school medical personnel my consent and authorization to render such aide, treatment or care to said student as, in the judgment of said doctor, hospital, or school medical personnel may be required, on an emergency basis, in the event said student should be injured or stricken ill while involved in activity by the above named school.

\_\_\_\_\_  
(Parent/Guardian signature) (Date)

I, \_\_\_\_\_ acknowledge the risk of sports' participation described above. I realize that while most injuries are minor or moderate, there is a possibility of severe injury, or even death. I understand that adherence to the rules and coaches' instructions may minimize this risk, and I agree to report all injuries or medical problems to my coach, athletic trainer, and/or school medical/administrative authorities.

\_\_\_\_\_  
(Student signature) (Date)

## SECTION 2: HEALTH HISTORY (PARENT/STUDENT COMPLETES)

<b>Do you/have you...</b>	<b>YES</b>	<b>NO</b>	<b>Explain "YES" answers here:</b>
1. Ever been hospitalized, had surgery, or had/have any chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Currently taking prescription/over-counter medication? Which? Dosage?	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Have allergies to medication/pollen/food/stinging insects? Any severe?	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Have any skin problems, rashes? Any during/after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Any vision problems? Contacts/Glasses?	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Ever passed out or nearly passed out <u>during or after</u> exercise?	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Ever had excessive/unexplained fatigue associated w exercise?	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Had any chest discomfort/pain/pressure during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Tire more quickly than his peers during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Ever had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Ever been told he has a heart murmur, arrhythmia, or heart infection?	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Ever had a racing of the heart or skipped beat? During exercise?	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Had a doctor ever ordered a test (ECG, echocardiogram) for you?	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. Had one or more relatives died of heart problems or sudden death before 50?	<input type="checkbox"/>	<input type="checkbox"/>	_____
15. Had a close relative <50 with a disability from heart disease?	<input type="checkbox"/>	<input type="checkbox"/>	_____
16. Had anyone in your family with a heart problem or do you have specific knowledge of the following cardiac conditions in family members: hypertrophic or dilated cardiomyopathy, long QT syndrome, Marfan's Syndrome, clinically important arrhythmia or heart rhythms?	<input type="checkbox"/>	<input type="checkbox"/>	_____
17. Ever had rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>	_____
18. Had a cough/trouble breathing during or after exercise, or has he been diagnosed with asthma? If yes, is he on medication/inhaler for this?	<input type="checkbox"/>	<input type="checkbox"/>	_____
19. Had heat cramps, heat illness, or heat stroke during or after exercise, or are you prone to heat illness?	<input type="checkbox"/>	<input type="checkbox"/>	_____
20. Get frequent headaches? Headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>	_____
21. Ever had a concussion or head injury?	<input type="checkbox"/>	<input type="checkbox"/>	_____
22. Ever been hit in the head and been confused, had "bell rung" or lost memory?	<input type="checkbox"/>	<input type="checkbox"/>	_____
23. Ever been unconscious as a result of a blow to the head?	<input type="checkbox"/>	<input type="checkbox"/>	_____
24. Had tingling/numbness/weakness in arms or legs after injury?	<input type="checkbox"/>	<input type="checkbox"/>	_____
25. Ever been unable to move arms or legs after injury?	<input type="checkbox"/>	<input type="checkbox"/>	_____
26. Missing or have nonfunctional paired organ (eye, kidney, testicle or other organ)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
27. Get chronic sore throats or have sinus problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
28. Have a hearing deficiency?	<input type="checkbox"/>	<input type="checkbox"/>	_____
29. Ever had TB, Valley fever, hepatitis, or any infectious/viral disease? Any recent (esp myocarditis, mononucleosis, etc)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
30. Ever experienced a seizure? Any recent seizures?	<input type="checkbox"/>	<input type="checkbox"/>	_____
31. Had any skin lesions/sores, rashes, or herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>	_____
32. Had a doctor tell you/family member you have sickle cell trait /sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>	_____
33. Use any prescr./non-prescr. supplement to gain/lose weight/improve performance?	<input type="checkbox"/>	<input type="checkbox"/>	_____
34. Had any medical problems since last evaluation, or ever been denied /restricted participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	_____
35. Is there any other medical concern that the BCP medical care providers should know or restrictions on you for athletic participation?	<input type="checkbox"/>	<input type="checkbox"/>	_____

**SECTION 3: EMERGENCY INFORMATION (PARENT COMPLETES)**

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

1) \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
2) \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
Family Physician: \_\_\_\_\_ Office Phone: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Preferred Hospital: \_\_\_\_\_

**SECTION 4: INJURY HISTORY (PARENT/STUDENT COMPLETES)**

Have you had an injury that caused you to miss a practice or game, or required imaging (x-ray, MRI, CT scan, etc), or required surgery, rehabilitation, special protective device (include significant strain, sprain, dislocation, instability, joint injury, fracture, etc)?  
YES  NO

If YES, circle below, and explain to the right:

Head	Neck	Shoulder	Upper Arm
Elbow	Forearm	Hand/Fingers	Chest
Back	Hip	Thigh	Knee
Calf/Shin	Ankle	Foot	Toes

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION 5: TRUTH DISCLOSURE ACKNOWLEDGMENT (PARENT/STUDENT COMPLETES)**

I hereby state, to the best of my knowledge, the answers to the questions in sections 1-4 are complete and correct.

\_\_\_\_\_  
(signature of parent/guardian)

\_\_\_\_\_  
(signature of student)

\_\_\_\_\_  
(date)

**SECTION 6: MEDICAL EXAMINATION SECTION (MEDICAL PERSONNEL COMPLETES)**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_, \_\_\_\_\_ / \_\_\_\_\_, \_\_\_\_\_ / \_\_\_\_\_ ) Pulse(s): \_\_\_\_\_  
Vision: Right=20/ \_\_\_\_\_ Left=20/ \_\_\_\_\_ (Corrected? YES NO) Pupils: Equal \_\_\_ Unequal \_\_\_ Body Fat %: \_\_\_\_\_

Follow-up questions on more sensitive issues:

1. Do you feel stressed out or under a lot of pressure? YES  NO   
2. Do you ever feel so sad or hopeless that you stop doing normal activities for more than a few days? YES  NO   
3. Do you feel safe? YES  NO   
4. Have you ever tried smoking or smokeless tobacco? YES  NO   
5. Do you currently use tobacco or used in past 30 days? YES  NO   
6. Have you had a least 1 alcoholic drink in past 30 days? YES  NO   
7. Have you ever taken anabolic steroids? YES  NO   
8. Have you ever taken supplements to help gain/lose wt? YES  NO

Notes: \_\_\_\_\_  
\_\_\_\_\_

MEDICAL	NORMAL	ABNORMAL FINDINGS	INIT'S
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitourinary			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck/Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

Cleared w/out restriction  Cleared with recommendations for further evaluation/treatment for: \_\_\_\_\_  
 Not cleared for:  All sports  Certain sports Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Name of Physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Physician \_\_\_\_\_, MD, DO, NP, PA-C  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_