

**SETON CATHOLIC CENTRAL ATHLETIC MEDICAL INFORMATION**

**PLEASE PRINT:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Grade in Sept. \_\_\_\_\_ Date Entered 9<sup>th</sup> Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age Sept. 1<sup>st</sup> \_\_\_\_\_

Address \_\_\_\_\_ School \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BLOOD PRESSURE \_\_\_\_\_

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**PLEASE CIRCLE:** YES or NO

**HAVE YOU EVER HAD:**

Allergies/Hay Fever	YES	NO	Elevated Blood Pressure		YES	NO
Bee Sting Allergy	YES	NO	Headaches		YES	NO
Asthma	YES	NO	Head Injury/Concussion		YES	NO
Arthritis	YES	NO	Heart Problem/Murmur/Chest Pains		YES	NO
Bladder/Kidney Problem or Injury	YES	NO	Nose Bleeds/Frequent or Severe		YES	NO
Convulsions/Seizures	YES	NO	Ankle Injury		YES	NO
Fainting Spells	YES	NO	Back Pain/Injury	YES	NO	
Diabetes	YES	NO	Fracture-Dislocation Bones/Joints		YES	NO
Ear Problems/ Hearing Loss	YES	NO	Knee Pain/Injury	YES	NO	
Eye Problems/Vision Loss	YES	NO	Neck Injury		YES	NO
Injury to the Spleen	YES	NO	Rheumatic Fever		YES	NO
Joint Sprain/Ligament Tear/Muscle Pull	YES	NO	Stomach Ulcer		YES	NO

Have you been Unconscious or Lost Memory from a blow on the head? YES NO

**Do you have any of the following:** One Kidney? YES NO One Testicle? YES NO  
 One Eye or Severe Uncorrectable Loss of Vision in one or both eyes? YES NO  
 Severe Hearing Loss in both ears? YES NO

Have you been ill for 5 consecutive days? YES NO

Have you ever had an illness, condition or injury that required you to go to the hospital either as a patient overnight or in the Emergency Room or for X-rays; required an Operation; caused you to miss a game or practice? \_\_\_\_\_

Are you under medical care now? YES NO

Have you taken medication in the past year? YES NO If so, why? \_\_\_\_\_

Are you taking medication now? YES NO If so, why? \_\_\_\_\_

Have you ever fainted **during** exercise? YES NO Explain \_\_\_\_\_

Has there ever been sudden death in a family member under fifty (50) years of age? YES NO

**Do you have:** Orthodontic Appliances? YES NO Capped Teeth? YES NO  
 Wear Contact Lenses for sports? YES NO Wear Glasses for sports? YES NO

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**CIRCLE** the team or teams you intend to play on this year:

FOOTBALL CROSS COUNTRY CHEERLEADING SOCCER  
 TRACK GOLF TENNIS BASKETBALL  
 BASEBALL SOFTBALL LACROSSE FIELD HOCKEY

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CHEST \_\_\_\_\_ HEART \_\_\_\_\_ LUNGS \_\_\_\_\_ HERNIA \_\_\_\_\_

THIS CERTIFIES THAT THE ABOVE NAMED IS PHYSICALLY QUALIFIED TO PARTICIPATE IN THE FOLLOWING CATEGORIES OF COMPETITION DURING THE SCHOOL YEAR. (ANY **CIRCLED** CATEGORY INDICATES **DISQUALIFICATION** FOR THE PARTICULAR GROUP OF SPORTS ACTIVITIES LISTED.)

<u>CONTACT/COLLISION</u>	<u>LIMITED CONTACT/IMPACT</u>	<u>STRENUOUS NONCONTACT</u>	<u>NONSTRENUOUS NONCONTACT</u>
FOOTBALL	BASEBALL	CHEERLEADING	GOLF
LACROSSE	BASKETBALL	CROSS COUNTRY	
SOCCER	SOFTBALL	TRACK and FIELD	
FIELD HOCKEY		TENNIS	

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_