Expiration Date: ___/___/_____

2023-2024 PHYSICAL FORM (Medical History & Physician Examination)

LEGAL NAME: _____ CHOSEN NAME: _____ DOB:___/___/___ GRADE (23-24):____ GENDER:_____

This **MEDICAL HISTORY FORM** must be completed annually by a parent (or guardian) and the student in order for the student to participate in activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an event. Explain "Yes" answers in the box below**. Circle questions you don't know the answers to.

1. Have you had a medical illness or injury since your last check up or sports physical? ☐Yes ☐No
2. Have you been hospitalized overnight in the past year? Yes No Have you ever had surgery? ☐Yes ☐No
3. Have you ever had prior testing for the heart ordered by a physician? ☐Yes ☐No
   Have you ever passed out during or after exercise? ☐Yes ☐No
   Have you ever had chest pain during or after exercise? ☐Yes ☐No
   Do you get tired more quickly than your friends do during exercise? ☐Yes ☐No
   Have you ever had racing of your heart or skipped heartbeats? ☐Yes ☐No
   Have you had high blood pressure or high cholesterol? ☐Yes ☐No
   Have you ever been told you have a heart murmur? ☐Yes ☐No
   Has any or relative died of heart problems or of sudden unexpected death before age 50? ☐Yes ☐No
   Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm? ☐Yes ☐No
   Have you had a severe viral infection (myocarditis, mononucleosis, COVID) w/in the last month? ☐Yes ☐No
   Has a physician ever denied or restricted your participation in activities for any heart problems? ☐Yes ☐No
4. Have you ever had a head injury or concussion? ☐Yes ☐No
   Have you ever been knocked out, become unconscious or lost your memory? ☐Yes ☐No
   If yes, how many times? __When was your last concussion? _____ How severe was each one? (Explain below)
   Have you ever had a seizure? ☐Yes ☐No
   Do you have frequent or severe headaches? ☐Yes ☐No
   Have you ever had numbness or tingling in your arms, hands, legs, or feet? ☐Yes ☐No
   Have you ever had a stinger, burner, or pinched nerve? ☐Yes ☐No
5. Are you missing any paired organs? ☐Yes ☐No
6. Are you under a doctor's care? ☐Yes ☐No
7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler? ☐Yes ☐No
8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? ☐Yes ☐No
9. Have you ever been dizzy during or after exercise? ☐Yes ☐No
10. Do you have any current skin problems (i.e, itching, rashes, acne, warts, fungus, or blisters)? ☐Yes ☐No
11. Have you ever become ill from exercising in the heat? ☐Yes ☐No
12. Have you had any problems with your eyes or vision? ☐Yes ☐No
13. Have you ever gotten unexpectedly short of breath with exercise? ☐Yes ☐No
    Do you have asthma? ☐Yes ☐No
    Do you have seasonal allergies that require medical treatment? ☐Yes ☐No
14. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or activity (i.e, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? ☐Yes ☐No
15. Have you ever had a sprain, strain, or swelling after injury? ☐Yes ☐No
    Have you broken or fractured any bones or dislocated any joints? ☐Yes ☐No
    Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? ☐Yes ☐No
    If yes, check appropriate box and explain below. ☐ Head ☐ Elbow ☐ Hip ☐ Neck ☐ Forearm ☐ Thigh ☐ Back ☐ Wrist ☐ Knee ☐ Chest ☐ Hand ☐ Shin/Calf ☐ Shoulder ☐ Finger ☐ Ankle ☐ Upper Arm ☐ Foot
16. Do you want to weigh more or less than you do now? ☐Yes ☐No
17. Do you feel stressed out? ☐Yes ☐No
18. Have you ever been diagnosed with or treated for sickle cell trait or cell disease? ☐Yes ☐No

Females Only

19. When was your first menstrual period? _____ When was your most recent menstrual period? _____
    How much time do you usually have from the start of one period to the start of another? _____
    How many periods have you had in the last year? ___ How much time do you usually have from the start of one period to the start of another? _____ What was the longest time between periods in the last year? _____

Males Only

20. Do you have two testicles? ☐Yes ☐No
21. Do you have any testicular swelling or masses? ☐Yes ☐No

An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question three above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner.
**EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):

_____
_____
_____
_____
_____

It is understood that even though protective equipment is worn by athletes, whenever needed, the possibility of an accident still remains. The school does not assumes any responsibility in case an accident occurs If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student. If, between this date and the beginning of participation, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the School.

Student Signature: _____ Date: _____

Parent/Guardian Signature:_____ Date: _____

This **PHYSICIAN EXAMINATION FORM** must be completed annually and "cleared" by a physician for the student to participate in activities. The expiration date is one year after the physician's examination.

Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in Meridian School practices, games, or matches. THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE, PERFORMANCE, OR CONTEST BEFORE, DURING OR AFTER SCHOOL

Meridian School policy requires an annual physical exam.

Age _____ Height _____Weight_____ % Body fat (optional) _____
Pulse _____ BP____/____ (____/____, ____/____) brachial blood pressure while sitting
Vision R 20/_____ L 20/___ Corrected: ☐Yes ☐No Pupils: Equal / Unequal

Medical	Normal	Abnormal Findings	Initials*
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position.			
Heart-Auscultation of the heart in the standing position.			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only.

CLEARANCE (TO BE COMPLETED BY PHYSICIAN)

☐ CLEARED

☐ CLEARED AFTER completing evaluation/rehabilitation for:

_____
_____

☐ NOT CLEARED for:_____

Reason_____

Recommendations:_____

_____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner will not be accepted.

Physician Name (print/type):_____

Address:_____

Phone Number: _____

Physician's Signature: _____

➔ **IMPORTANT! Date of Examination: ____/____/_____**

Must be completed and processed by the Athletics Department before a student participates in any way, including tryouts, practice, or performance/games/matches (before, during, after school, in or out of season).
FOR SCHOOL USE ONLY.

This Physical Form was received by (printed name):_____

Signature of processor: _____ Processed on (date): _____