

ARCHBISHOP WALSH ACADEMY ANNUAL PHYSICAL FORM

Name _____ Birthdate _____ Address _____

Medical History _____

Immunizations (Additional since last examined) _____

Date of exam _____ Medical Examination (Use Medical Code Listed Below)

Height _____ Eyes _____ Ears (Otoscopic) _____

Weight _____ Vision: Right _____ Left _____ Hearing: Right _____ Left _____

Lymph Nodes _____
 Thyroid _____
 Nose _____
 Tonsils _____
 Teeth _____
 Gums _____
 Heart _____
 Blood Pressure _____
 Lungs _____
 Abdomen _____
 Hernia _____
 Nervous System _____

Genito Urinary _____
 Tanner _____
 Urine: _____
 Glucose _____
 Protein _____
 Orthopedic: _____
 Structural _____
 Posture _____
 Feet _____
 Skin _____
 Nutrition _____
 General Condition _____

Remarks : (Explain any defects found here) _____

Medical Code (Use in recording medical examination findings)

Blank- No defects; X- Defect under observation; XX- Defect reportable and requiring Treatment; I- Irremedial defect; T- Defect under treatment or treated.

Return Completed Form to:
 ArchBishop Walsh High School
 Attention: School Nurse
 208 North 24th Street
 Olean, NY 14760
 Phone: 372-8122

 Physician's Signature

STUDENT PARTICIPATION AND PARENTAL APPROVAL FORM

2009-2010 School Year

USE PEN ONLY PLEASE:

SPORT (S) _____ DATE _____ GRADE _____ HOME ROOM _____

STUDENT NAME _____ SEX _____ DOB _____

FAMILY PHYSICIAN _____

This application to compete in interscholastic athletics is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the State Association.

Signature of Student _____

Date of last Diphtheria/Tetanus shot _____

Asthma _____

Allergies (please list) _____

Seizures _____

Diabetes _____

Do you take medication for any of the above? If so, please list _____

Contact Lenses: Yes _____ No _____ Glasses: Yes _____ No _____

I hereby give my consent for _____ to represent Arch-Bishop Walsh in athletic activities, both interscholastic and intramurals (recreation) and to accompany the team on its out-of-town trips.

I authorize the school physician, nurse or athletic trainer to disclose any injury/illness information to the coach who is employed by the school district and will keep all information confidential. I also authorize Arch-Bishop Walsh, through its representative, to obtain any emergency medical care that may become necessary for the student in the course of such activities or travel. I also give my consent for any physician or health care unit selected by this representative to provide the emergency care deemed necessary.

Signature of Parent/Guardian _____ Date _____

Address _____

Home Phone _____ Emergency Phone _____

Your Health Insurance Company (which covers this student) _____

Policyholder _____ Policy/Group No. _____

NOTE: This form must be filled out completely and filed in the Medical Office

BEFORE THE STUDENT IS ALLOWED TO PARTICIPATE IN ANY OF THESE ACTIVITIES.

Archbishop Walsh Academy Athletic Health History

Name: _____ Birth Date: _____

Participation in athletics is voluntary and is not a required part of the regular physical education program.

Family Physician _____ Home Phone: _____

Grade: _____ Date: _____

Sports Activities:

Identify any sports in which you do not wish your child to participate. _____

This form must be completed and returned to the Medical Office.

Health History

(To be completed by parent)

Has your child ever had: (please check)	Yes	No		Yes	No
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Elevated Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Bee Sting Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury/Concussion	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problem/Murmur-Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Nose Bleeds/Frequent or Severe	<input type="checkbox"/>	<input type="checkbox"/>
Bladder/Kidney Problem or Injury	<input type="checkbox"/>	<input type="checkbox"/>	Ankle Injury	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain/Injury	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Fracture-Dislocation Bones/Joints	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Knee Pain/Injury	<input type="checkbox"/>	<input type="checkbox"/>
Ear Problems/Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Neck Injury	<input type="checkbox"/>	<input type="checkbox"/>
Eye Problems/Vision Loss	<input type="checkbox"/>	<input type="checkbox"/>	Nose Fracture	<input type="checkbox"/>	<input type="checkbox"/>
Injury to Spleen	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Joint Sprain/Ligament Tear/Muscle Pull	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Is there a current medical examination on file in the nurse's office?				<input type="checkbox"/>	<input type="checkbox"/>
Is your child assigned to the Adaptive Physical Education Program or has he/she been in an Adaptive Physical Education?				<input type="checkbox"/>	<input type="checkbox"/>
Has your child been unconscious or lost memory from a blow on the head?				<input type="checkbox"/>	<input type="checkbox"/>

Please explain any questions answered yes above: _____

(over)

History Continued

Does your child have any of the following: Yes No

- One Eye or Severe Uncorrectable Loss of Vision in one or both eyes _____
- Severe Hearing Loss in both ears _____
- One Kidney _____
- One Testicle _____
- Has your child been ill for five (5) consecutive days? _____

Has your child ever had an illness, condition, or injury that required him/her to go to the hospital, either as a patient overnight or in the emergency room or for x-rays; required an operation; caused your child to miss a game or practice? _____

Is your child under medical care now? _____

Has your child taken any medication in the past year? _____

If so, why? _____

Is your child taking any medication now? _____

If so, why? _____

Has your child ever fainted during exercise? _____

If so, explain _____

Has there ever been sudden death in a family member under fifty (50) years of age? _____

Do you have worries about your child's health or questions you would like to discuss with the doctor? _____

Does your child have : Orthodontic Appliances? _____

Capped Teeth? _____

Wear contact lens for sports? _____

Wear glasses for sports? _____

Since your child's last physical examination has your child had any injury or medical illness? _____

I agree with the above answers and consent to participation of my child in the interscholastic program of the Archbishop Walsh High School including practice sessions and travel to and from athletic contests.

I also agree to emergency medical treatment as deemed necessary by the physicians designated by school authorities.

Parent Signature _____ Date: _____