SETON CATHOLIC CENTRAL ATHLETIC MEDICAL INFORMATION

PLEASE PRINT:

Name: _____ Phone: _____

Grade in Sept. _____ Date Entered 9th Grade _____ Date of Birth _____ Age Sept. 1st _____

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.)

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

Physician's Signature: _____ Date: _____