St. Augustine High School
2020-2021 PHYSICAL AND RELEASE FOR PARTICIPATION

Name _____ Graduation Year_____ Date of Birth: _____

PART 1. MEDICAL HISTORY TO BE COMPLETED BY PARENT

Do you have now or have you ever had any of the following:

Yes	No		Explanation of "Yes" answers **REQUIRED –** please include dates
		Allergies (Food, Drug, Bees, etc.)	List: **Epi-Pen**: Yes No
		Asthma	Medications:
		Headaches or Migraines	
		Unconsciousness or Blackouts	
		Concussions or Head Injuries	Dates:
		Muscle Cramps	
		Sickle Cell Trait	
		Heat Illness (treated/hospital)	Dates:
		Had a heart screen (EKG or Echo)	Results:
		Dizziness during or after exercise	
		Passing out during or after exercise	
		High Blood Pressure	
		Heart Murmur or Abnormal beat	
		Racing heart or skipped heart beats	
		Discomfort, pain, tightness, or pressure in your chest during exercise?	
		Lightheaded or more short of breath than expected during exercise?	
		Family History of Heart Disease	
		Sudden Death in Family <50yrs	
		Epilepsy or Seizures	
		Diabetes	
		Kidney or Bladder Problems	
		Stomach Conditions or Ulcer	
		Mononucleosis	Date:
		Missing Organs	
		Skin Issues (rash, sores, MRSA)	
		Hearing/Speech Disorder	
		ADHD/ Learning Disability	List Medications:
		Anxiety/Depression	List Medications:
		Contact Lenses/Glasses	
		Surgeries	Body Part/Date:
		Joint Dislocations	Body Part/Date:
		Broken Bones/Stress Fractures	Body Part/Date:
		Sport Injuries - within past year (i.e. sprains, strains, etc.)	Body Part/Date:
		Use brace/orthotics/other device	
		Groin pain, painful bulge, sport hernia	
		Other Disorders/Diseases (past or present) w/ physician evaluation	List/Dates:
		Current Medications	List:

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Parents: I hereby give my consent for my son to compete in sports and/or physical education for St. Augustine High School and to travel with a representative of the school on sports-related trips. I authorize St. Augustine High School to secure emergency care for illness or injury sustained by Student and consent for Student to receive initial treatment by an Athletic Trainer, EMT, nurse, physician or other licensed health care professional or facility for treatment deemed necessary. I hereby fully release, discharge, hold harmless and agree to indemnify SAHS and its agents from all claims, financial responsibility and any liabilities whatsoever resulting from injuries (including death), damages and losses by Student and arising out of, connected with or in any way associated with their participation.

_____ _____ _____

Parent/Guardian Name (Print) **Parent/Guardian Signature** **Date**

2020-21 St. Augustine High School PHYSICAL FORM

Exp. Date_____

All freshmen, athlete, and transfer students MUST have a *current* physical on file no later than the FIRST day of school or practice, whichever comes first.

****TO BE ELIGIBLE FOR ATHLETICS PARTICIPATION: THIS PHYSICAL MUST BE PERFORMED AFTER June 1st, 2020****

NAME:		SPORT (S):	
BIRTH DATE:		AGE:	Graduation Year:
HEIGHT:		WEIGHT:	
BLOOD PRESSURE:		PULSE:	RESPIRATIONS:
VISION R	VISION L	PERL: ☐YES ☐NO	CORRECTIVE LENSES: ☐YES ☐NO

			COMMENTS:
APPEARANCE/SKIN	NORMAL_____	ABNORMAL_____	_____
EYES/EARS/NOSE/THROAT	NORMAL_____	ABNORMAL_____	_____
HEAD/NECK/LYMPHATICS	NORMAL_____	ABNORMAL_____	_____
CARDIOVASCULAR	NORMAL_____	ABNORMAL_____	_____
RESPIRATORY	NORMAL_____	ABNORMAL_____	_____
GASTROINTESTINAL	NORMAL_____	ABNORMAL_____	_____
NEUROLOGICAL	NORMAL_____	ABNORMAL_____	_____
MUSCULOSKELETAL			
NECK/BACK	NORMAL_____	ABNORMAL_____	_____
SHOULDER/ARM	NORMAL_____	ABNORMAL_____	_____
ELBOW/WRIST/HAND	NORMAL_____	ABNORMAL_____	_____
HIP/THIGH	NORMAL_____	ABNORMAL_____	_____
KNEE	NORMAL_____	ABNORMAL_____	_____
LEG/ANKLE/FOOT	NORMAL_____	ABNORMAL_____	_____

I certify that the medical history information has been reviewed and the above-named individual has been given a thorough physical examination covering the above information. The above-named individual is (CHECK ONE BELOW):

	Withheld from participation	Explain:
	Limited participation	Explain:
	Cleared for unlimited participation – No restrictions	

PHYSICIAN'S SIGNATURE:	**DATE:**
PRINTED NAME AND BUSINESS PHONE NUMBER/STAMP	