



St. Augustine High School

2021-22 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:

Table with 3 columns: Yes, No, and Explanation of "Yes" answers REQUIRED - please include dates. Rows include Allergies, Asthma, Headaches, Unconsciousness, Concussions, Muscle Cramps, Sickle Cell Trait, Heat Illness, Heart Screen, Dizziness, Passing out, High Blood Pressure, Heart Murmur, Racing heart, Chest discomfort, Short of breath, Family History, Sudden Death, Epilepsy, Diabetes, Kidney/Bladder, Stomach, Mononucleosis, Missing Organs, Skin Issues, Hearing/Speech, ADHD, Anxiety/Depression, Contact Lenses, Surgeries, Joint Dislocations, Broken Bones, Sport Injuries, Use brace, Groin pain, Other Disorders, Current Medications.

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.

Parent/Guardian Name (Print)

Parent/Guardian Signature

Date

Student Name and Grade (Print)

Student Signature

Date

**2021-22 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 ON OR AFTER June 1<sup>st</sup>, 2021\*\***

<b>NAME:</b>		SPORT (S):	
BIRTH DATE:		AGE:	Graduation Year:
HEIGHT:		WEIGHT:	
BLOOD PRESSURE:		PULSE:	RESPIRATIONS:
VISION R	VISION L	PERL: <input type="checkbox"/> YES <input type="checkbox"/> NO	CORRECTIVE LENSES: <input type="checkbox"/> YES <input type="checkbox"/> 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):**

<input type="checkbox"/>	Withheld from participation	Explain:
<input type="checkbox"/>	Limited participation	Explain:
<input type="checkbox"/>	Cleared for unlimited participation – No restrictions	

<b>PHYSICIAN'S SIGNATURE:</b>	<b>DATE OF EXAM:</b>
<b>PRINTED NAME AND BUSINESS PHONE NUMBER/STAMP</b>	