ST. TERESA CATHOLIC SCHOOL
1108 LEBANON AVENUE
BELLEVILLE, IL 62221

Dear Parents/Guardians:

Attached, you will find our St. Teresa sports physical form. The front of the form is to be completed by the parent including the parent/guardian's signature giving permission to participate. **The back of the form is to be completed and signed by the physician who performs the examination, including the date of the exam.**

Any student who plans to participate in school-sponsored sports must have a *current* (expires 395 days from the date of the medical examination) physical on file at the school office prior to participating in any practice or game. Incoming **Kindergarteners** and **Sixth graders** must have a new *Illinois state physical form* on file. Those students **do not** require an additional *sports* physical.

You are permitted to have the physicals done by the doctor of your choice. Please, be sure to provide the St. Teresa Sports Physical Form to the physician of your choice so that the doctor may complete the back page.

Please keep in mind that you will need to provide the physical form *before* Summer break, or you will need to mail or bring the form to the school office to be filed. This will ensure that the physical is on file at the school prior to the beginning of sports (soccer and baseball) practice (usually begins the last week of July). The coach will be notified if your child does not have a current physical on file.

If you choose to mail the completed form, please send to:

St. Teresa School
1108 Lebanon Avenue
ATTN: School Nurse/Sports Physical
Belleville, IL 62221

Please, do not hand sports physicals to the coach.

If you have any questions or concerns, please contact me at the school office Monday thru Friday during school hours at 235-4066.

Sincerely,

Janine L. Gosebrink, RN, BSN
Nurse
St. Teresa School

ST. TERESA CATHOLIC SCHOOL

1108 LEBANON AVENUE
BELLEVILLE, IL 62221

Name:_____
Gender:_____M _____F Date of Birth:_____/_____/_____
Father's Name:_____ Daytime/Cell Phone:(_____)_____-_____
Mother's Name:_____ Daytime/Cell Phone:(_____)_____-_____
Email Address:_____ Home Phone: (_____)_____-_____
Street Address:_____
City:_____State:_____Zip:_____
Alt. Emergency Contact:_____ Daytime/Cell Phone:(_____)_____-_
Please indicate MEDICAL ALERTS such as allergic reactions, contact lenses, etc.:_____
_____

MEDICAL HISTORY

Athletes and Parents: This health record is a critical element in the determination of an athlete's risk of injury in sports. Please take the time to read and answer all questions before seeing a physician for the athlete's physical examination.

1. Has anyone in the athlete's family (grandparents, mother, father, brother, sister, aunt, uncle) died suddenly before age 50?	YES ☐	NO☐	DON'T KNOW☐
2. Has the athlete ever stopped exercising because of dizziness or passed out during exercise?	YES ☐	NO☐	DON'T KNOW☐
3. Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise?	YES ☐	NO☐	DON'T KNOW☐
4. Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint?	YES ☐	NO☐	DON'T KNOW☐
5. Does the athlete have a history of concussion (getting knocked out)?	YES ☐	NO☐	DON'T KNOW☐
6. Has the athlete ever suffered a heart-related illness (heat stroke)?	YES ☐	NO☐	DON'T KNOW☐
7. Does the athlete have a chronic illness or see a doctor regularly for any particular problem?	YES ☐	NO☐	DON'T KNOW☐
8. Does the athlete take any medication(s)?	YES ☐	NO☐	DON'T KNOW☐
9. Is the athlete allergic to any medications or bee stings?	YES ☐	NO☐	DON'T KNOW☐
10. Does the athlete have only one of any paired organs? (eyes, ears, kidneys, testicles, ovaries)	YES ☐	NO☐	DON'T KNOW☐
11. Has the athlete had an injury in the last year that caused the athlete to miss 3 or more consecutive days of practice or competition?	YES ☐	NO☐	DON'T KNOW☐
12. Has the athlete had surgery or been hospitalized in the past year?	YES ☐	NO☐	DON'T KNOW☐
13. Has the athlete missed more than 5 consecutive days of participation in usual activities because of illness, or has the athlete had a medical illness diagnosed that has not been resolved in the past year?	YES ☐	NO☐	DON'T KNOW☐
14. Are you, the athlete, worried about any problem or condition at this time?	YES ☐	NO☐	DON'T KNOW☐

Additional Cardiovascular History

15. Have you ever had chest pain during or after exercise?	YES ☐	NO☐	DON'T KNOW☐
16. Do you get tired more quickly than your friends do during exercise?	YES ☐	NO☐	DON'T KNOW☐
17. Have you ever had racing of your heart or skipped heartbeats?	YES ☐	NO☐	DON'T KNOW☐
18. Have you ever had high blood pressure or high cholesterol?	YES ☐	NO☐	DON'T KNOW☐
19. Have you ever been told you have a heart murmur?	YES ☐	NO☐	DON'T KNOW☐
20. Have you ever had a severe viral infection (for example myocarditis or mononucleosis) within the last month?	YES ☐	NO☐	DON'T KNOW☐
21. Has a physician ever denied or restricted your participation in sports for any heart problems?	YES ☐	NO☐	DON'T KNOW☐
22. Has anyone in your family had a heart attack before the age of 50?	YES ☐	NO☐	DON'T KNOW☐

Please give details on any "YES" answer from the above health history:_____
_____
_____
_____
_____

Signature of Parent or Guardian:_____Date:____/_____/_____

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SPORTS PHYSICAL FORM

Student Name:_____

Grade:_____

Date of Exam:_____/_____/_____

PHYSICAL EXAM – TO BE COMPLETED BY PHYSICIAN

Height:_____ Weight:_____ Pulse:_____ Blood Pressure:_____/_____

Vision:

R_____/_____ Uncorrected R_____/_____ Corrected

L_____/_____ Uncorrected L_____/_____ Corrected

		Normal	Abnormal Findings	Initials
1.	Eyes			
2.	Ears, Nose, Throat			
3.	Mouth & Teeth			
4.	Neck			
5.	Cardiovascular			
6.	Chest & Lungs			
7.	Abdomen			
8.	Skin			
9.	Genitalia-Hernia (male)			
10.	Muskulosketal: ROM, strength, etc.			
a.	neck			
b.	spine			
c.	shoulders			
d.	arms/hands			
e.	hips			
f.	thighs			
g.	knees			
h.	ankles			
i.	feet			
11.	Neuromuscular			

Please Print/Stamp

Physician's Name:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Telephone:(_____)_____-_____

I certify that I have examined this athlete and found him/her medically qualified to participate in sports. I also certify that I am a licensed medical physician, physician's assistant, or family nurse practitioner. (Doctor of Chiropractic Medicine is not satisfactory.)

Physician Signature:_____ Date:_____/_____/_____