Nazareth Regional High School
Admission/Athletic Medical

Last Name:_____ First Name:_____Date Of Birth:_____
Address:_____ Home Phone:_____Grade:_____
Parent/Guardian:_____ Work #_____ Cell #_____
Other emergency contact name:_____ Phone #_____Sport(s):_____

To be completed by Physician:

Health History: (please explain any "yes" answers)

	Yes	No		Yes	No
Allergies			Concussion/Head injury		
Anaphylaxis- epi-pen			Diabetes		
Asthma			Fainting		
Blood Disorder			Hearing Loss		
Cardiac			Kidney/Genito-Urinary		
-family history of sudden death before age 35			Menstrual Problems LMP_____		
-fainting/dizzy during exercise			Testicular Problems/Hernia		
-chest pain, severe shortness of breath, fatigue during exercise			Migraines		
(please note: if any of the above are marked "yes", a cardiology clearance is required)			Neurological		
Wears glasses/contacts			Mental Health Issues		
Braces			Nose Bleeds/Sinus		
Protective Equipment (goggles, mouth guard)			Seizures		
Presently taking Medication			Previous Injuries		
Orthopedic Problems			Past Hospitalization		
Chronic Medical Conditions			Past Surgery		

Comments on any marked "yes":_____

Physical Exam

Height_____ Weight_____ Blood Pressure_____ Pulse_____

	Normal	Comment/Follow-up		Normal	Comment/Follow-up
General Condition			Gastro Intestinal		
Skin			Lungs		
Ears			Genito-Urinary		
Eyes			Neurological		
Nose			Musculoskeletal		
Throat			Spinal		
Mouth/Dental			Nutritional Status		
Cardiovascular			Mental Health		

SCREENING: Date Results Chest X-Ray (If Pos.)
TB: PPD ____ _____ _____
Hct:_____ Hgb:_____

VISION:
Right ____/____
Left ____/____
Both ____/____

HEARING:
Right – Pass Fail
Left – Pass Fail

Immunization History

DPT/DTaP or DT or Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
IPV/OPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Hepatitis B	___/___/___	___/___/___	___/___/___		
HIB	___/___/___	___/___/___	___/___/___	Meningococcal	___/___/___
MMR	___/___/___	___/___/___			___/___/___
VZV	___/___/___	___/___/___	Tdap ___/____/___		
Other	___/___/___	___/___/___			

Additional Comments:_____
Restrictions, limitations or special alerts that would interfere with students participation in sports/gym:_____
_____

I certify that I have examined the above named student and have obtained a health history from the parent and student. I find that he/she is physically fit and able to participate in competitive/contact sports at the high school level without restrictions, unless noted above.

_____ _____
Physician's Name Physician's Signature

_____
Address Date of Exam: _____/_____/_____

Phone Number_____

PHYSICIAN'S STAMP