



St. Margaret's Episcopal School Sports Physical

2007/2008

31641 La Novia, San Juan Capistrano, California 92675
Phone 949-661-0108 Fax 949-240-1496

This form is required only for students who participate in athletics at St. Margaret's. All students planning to participate in any athletic competition during the school year must return this form completed and signed prior to the beginning of their sports season. Students may not tryout, practice, or compete on any school team during the year until their approved forms are on file with the athletic department.

Name (please print) _____ Sex M/F Grade ____ Date of Birth ___/___/___
last first m.i.

I certify that my child named above is in good health and hereby give consent for my child to compete in sports and travel with a representative of the school on any trips. I understand that inherent risks exist in playing all sports. In the event of an emergency, I allow the school representative to authorize any medical treatment.

Signature of parent/guardian _____ Date _____
(signature required)

Home Phone _____

Health History (to be completed by parent before the physician's exam)

Any past or present:	Yes	No		Yes	No
Eyeglasses/Contacts	_____	_____	False teeth	_____	_____
Blacking out or fainting	_____	_____	Painful joints	_____	_____
Unconsciousness	_____	_____	Broken bones	_____	_____
Convulsions/Seizures	_____	_____	Part, date _____		
Heart problems	_____	_____	Knee/ankle problems	_____	_____
Bleeding disorder	_____	_____	Req. support brace	_____	_____
Blood sugar problems	_____	_____	Menstruation problems	_____	_____
Hypoglycemia	_____	_____	Hernias	_____	_____
Diabetes	_____	_____	Asthma	_____	_____
Allergies – type _____	_____	_____	Need for medication	_____	_____
Bee/insect sensitivity	_____	_____	Name of medication _____		
Surgeries _____	_____	_____			

Other health aspects the doctor and school should be aware of:

Athletic Screening (to be completed by physician)

Physical Exam: Height _____ Weight _____
Pulse: Resting _____ After Activity _____ B.P. _____

Eyes _____	Lymph Glands _____	Spleen _____
Ears _____	Cardiovascular _____	Kidney _____
Nose _____	Thyroid _____	Posture _____
Throat _____	Lungs _____	Muscle Tone _____
Teeth _____	Abdomen _____	Reflexes _____
Asthma _____	Hernia _____	Orthopedic _____
Medication _____	Liver _____	Skin _____
Dose _____ Time _____		Other _____
Student may carry medication Yes ____ No ____		

I have examined the above items and do recommend that this child is capable of participation in sports, except with the restrictions noted below.

Restrictions: ____ No ____ Yes (List Restrictions below)

Name of Physician (please print) _____

Signature of Physician _____

Date _____

OFFICE STAMP (required)

Both parent and physician signatures are required for completion of this form and student participation in athletics.