



Coyle and Cassidy High School

Athlete's Name:		Gender:	Age:
Date of Birth:	Grade:	Sport:	
Address:		City:	State:
Home Phone:	Parent's Work Phone:	Emergency Phone:	
Personal Physician:	Date of Most Recent Physical Exam:	Physician Phone:	
Personal Dentist:	Dentist Phone:	Health Insurance Company:	

	Yes	No
1. Have you been hospitalized or had surgery in the last two years?		
2. Are you presently taking any medications?		
3. Do you have any allergies (medications, bees, etc.)		
4. Have you ever been told you have a heart murmur?		
5. Have you ever had any seizures or fainting spells?		
6. Do you have any skin problems (itching, rashes, acne?)		
7. Have you ever had a head injury or been knocked unconscious?		
8. Have you ever had a stinger, burn, or pinched nerve?		
9. Have you ever been told by a physician that you have asthma?		
10. Do you wear glasses/contacts or have any other problems with your eyes?		
11. Have you ever had any fractures, dislocations or any repeated strains/sprains?		
12. Have you had any other medical problems (mononucleosis, diabetes, anemia, thyroid trouble, etc.)		
13. Have you ever had a hernia?		
<i>Females only:</i>		
When was your first menstrual period?		
When was your last menstrual period?		
What was the longest time between menstrual periods, last year?		
Are you currently having any difficulty with your periods? (Yes/No)		

If you answered "yes" to any of the questions above, please explain in detail below:

This screening is meant as a pre-athletic participation screening only and is not meant to take the place of a recommended annual physical by your primary physician.

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Parent's signature:	Date:
Athlete's signature:	Date:

AUTHORIZATION FOR MEDICAL TREATMENT

I give my permission for the evaluation/treatment of _____ by the certified athletic trainer and any duly licensed physician and/or hospital facility in the event of illness or injury. I also authorize transportation in an ambulance if necessary.

Date:	Parent/Guardian Signature:	Home Phone:	Work Phone:
Address:		City:	State: Zip:
Alternate Emergency Contact Person:		Home Phone:	Work Phone:
Athlete's Physician's Name and Phone:			Athlete's Date of Birth:



Coyle and Cassidy High School

2 Hamilton Street
 Taunton, MA 02780
 (508) 823-6164

Medical Screening Results

Athlete's Name:		DOB:		Date of Current Physical:	
Height:		Weight:		BP:	
Pulse:		Vision: Right 20/_____ Left 20/_____		Corrected? Yes/No	
Pupils:					
System		Normal Findings <i>(check if "yes")</i>		Abnormal Findings <i>(please note year)</i>	
Cardiopulmonary					
Pulses					
Heart					
Lungs					
Skin					
Abdomen					
Musculoskeletal					
Neck					
Shoulder					
Elbow					
Wrist/Hand					
Back					
Knee					
Ankle/Foot					
Other:					

Immunizations:

Please check one:

<input type="checkbox"/>	Cleared for full participation
<input type="checkbox"/>	Not cleared due to:
Physician's Name:	
Physician's Signature:	
Physician's Phone #:	
Additional Comments:	