



NOTRE DAME HIGH SCHOOL

A College Preparatory School of Excellence
13645 Riverside Drive Sherman Oaks CA 91423

Medical Authorization and Agreement to be Governed

I authorize and consent to my child, a minor, receiving x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care deemed necessary under general or special supervision and upon the advice of a physician and/or surgeon licensed under the medical practice act in accordance with section 25.8 of the California Civil Code. It is understood that every reasonable effort shall be made to contact the undersigned prior to rendering treatment.

- Agree
 Disagree

The Student-Parent Handbook is published to provide information regarding the rules, policies, and procedures that govern students and parents at Notre Dame High School. In order to ensure that parents and students have read the **Student-Parent Handbook**, and agree to be governed by this handbook, it is necessary that both student and parent agree to the statement found below.

We have read the current Student-Parent Handbook, and agree to be governed by this handbook.

- Agree
 Disagree

Your signature below acknowledges the above agreements and the accuracy of the information included on this form.

Parent /Guardian: _____

Signature: _____ Date: _____

Parent /Guardian: _____

Signature: _____ Date: _____

Student: _____ Student ID: _____

Signature: _____ Date: _____

Preparticipation Physical Evaluation

HISTORY FORM

DATE OF EXAM _____

Name _____ Sex _____ Age _____ Date of birth _____

Grade _____ School _____ Sport(s) _____

Address _____ Phone _____

Personal physician _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ (W) _____

**Explain "Yes" answers below.
Circle questions you don't know the answers to.**

	Yes	No		Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	25. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30. Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	31. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a doctor ever told you that you have (check all that apply):			32. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High blood pressure			33. Have you every had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High cholesterol			34. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> A heart murmur			35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> A heart infection			36. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	37. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	39. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
14. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	41. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	42. Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	43. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:	<input type="checkbox"/>	<input type="checkbox"/>	44. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	45. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	46. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/toes

20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	47. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>	48. How old were you when you had your first menstrual period? _____		
22. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	49. How many periods have you had in the last 12 months? _____		
23. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>	Explain "Yes" answers here: _____		

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.
 Signature of athlete _____ Signature of parent/guardian _____ Date _____

Preparticipation Physical Evaluation

PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

Height _____ Weight _____ % Body fax (optional) _____ Pulse _____ BP _____ / _____ (_____ / _____ , _____ / _____)

Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

Follow-Up Questions on More Sensitive Issues

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Do you feel stressed out or under a lot of pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you feel safe? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. During the past 30 days, did you use chewing tobacco, snuff, or dip? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. During the past 30 days, have you had a least 1 drink of alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever taken steroid pills or shots without a doctor's prescription? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever taken any supplements to help you gain or lose weight or improve your performance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Questions from the Youth Risk Behavior Survey (http://www.cdc.gov/HealthyYouth/yrbs/index.htm) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc. | <input type="checkbox"/> | <input type="checkbox"/> |

Notes: _____

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)*			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only.

*Having a third party present is recommended for the genitourinary examination.

Notes: _____

Name of physician (print/type) _____ Date: _____

Address _____ Phone: _____

Signature of physician _____, MD or DO