BISHOP McNAMARA HIGH SCHOOL
MEDICAL EVALUATION OF STUDENT

(Please circle) Grade: 9 10 11 12

____ ____/____/____ **Male/ Female**

Last Name First Name MI D.O.B (Please circle)

Sports Played: ______________________, ___________________________, ____________________________________

PART I: MEDICAL HISTORY
(TO BE COMPLETED BY PARENT OR GUARDIAN)

YES	NO	
		1. Have you ever had any illness/injury requiring serious medical attention, hospitalization, or surgery?
		2. Do you have any condition currently being treated by a physician?
		3. Are you currently taking any medication(s)? List below
		4. Do you have any allergies? List all below
		5. Do you have any medical condition that should be known in case of emergency? Explain below
		6. Do you wear glasses, contact lenses, or protective eyewear? Explain below
		7. Have you ever had a concussion? If so when? _______________

If you answered YES to any questions, please explain: ____

____

____

PART II: PHYSICAL EXAMINATION
(TO BE COMPLETED BY A PHYSICIAN OR UNDER HIS SUPERVISION)

Height: ___________ Weight: ___________ Blood Pressure: ___________ Pulse: ___________ Vision: ___________

System Checked	Normal	Abnormal	Not Examined	Explain
Cardiovascular				
Respiratory				
Abdomen				
Skin				
Neurological				
Orthopedic				
Oral				
Ears, Nose, Throat				
Other				

CLEARANCE:

- ☐ **CLEARED**
- ☐ **Cleared with RESTRICTIONS. Explain:**____
- ☐ **NOT CLEARED for :** _______________________________ **Reason:**____

____
Physician's Signature

Physician's Address / Stamp:

____
Physician's Printed Name

____________________ ____________________
Date of Examination **Phone #**