Cardinal Newman
HIGH SCHOOL

Physical Forms Packet

Please print out the following forms and take them with you to your doctor's appointment. Please fill out the first page and have the doctor fill out the last page.

Once the two pages are completed you can either turn them into the athletics office or you can add them directly to your student's SportsWare profile by either scanning the completed forms or taking a picture of the completed forms on your smart phone. The forms can then be added to the SportsWare profile by signing into your account and clicking on the Forms tab on the upper left-hand side. Then you will click on the Add button on the left side of the screen and you will be able to add the file from your computer or smartphone. Please title the new addition Physical Forms.

If you have any questions please email the athletic trainer, Lauren Dykema, at her e-mail dykema@cardinalnewman.org

Thank you!

Cardinal Newman High School Pre-Participation Physical Exam

This section to be completed by student; Please Print Date: _____

Student Name: _____ Birthdate: _____

School: Cardinal Newman High School, 50 Ursuline Road. Santa Rosa, CA 95403 Grade: _____

This application to compete in interscholastic athletics for Cardinal Newman High School is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the California Interscholastic Federation.

Student Signature: _____ Date: _____

Student/ Parent Risk Acknowledgement and Consent for Participation

_____ wishes to participate in the Cardinal Newman High School Athletic Program. We realize that there are risks involved in participation that include a full range of injuries, from minor to severe. We recognize the possibility that the athlete might die, become paralyzed, or suffer other permanent disability as a result of participation in this sports program. We agree to accept this risk as a condition of participation.

Student Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Authorization & Medical Release

This section to be completed by parent:

I the undersigned, being the parent or legal guardian of the above named student, hereby give my consent to Cardinal Newman High School to receive from or send to Dr._____ any information concerning my child.

I hereby give my consent for my child to represent his/her school in athletic activities and to accompany any school team of which he/she is a member on any of its local or out-of-town trips.

I hereby give my consent to any medical treatment deemed necessary by the athletic staff (athletic trainer, athletic director, or coach). If, in the judgement of any representative of the school the above-named student needs immediate care and treatment as may be given to said student by any physician, athletic trainer, nurse, hospital, or school representative. I do consent to the transportation of my child for participation in inter-scholastic athletics, and hereby grant any hospital, emergency center, doctor, nurse, EMT, and/or paramedic, authorization to grant treatment to my child when escorted to the treating facility by a teacher, coach, or other employee of Cardinal Newman High School. Further, should the attending physician determine after examination that life-saving surgery or other procedures might be necessary, permission is extended to the above parties to grant it.

Additionally, I agree to hold harmless such personnel and Cardinal Newman High School by my action of granting said permission. I also hereby waive and release Cardinal Newman from any and all liability for any injuries incurred by my child in the course of such athletic activities or travel. I have no knowledge of any physical impairments that would affect my child's participation in athletic activities or travel.

Print Parent Name: _____ Phone: _____

Parent Signature: _____ Date: _____

Athletic Insurance Verification

The California Education code requires insurance coverage in the amount of at least $1500.00 for medical and hospital expenses resulting from accidental bodily injury to members of any athletic team injured while participating in, or practicing for, interscholastic events or while being transported to and from such events. I hereby certify that there is held on behalf of _____, a student at CNHS, an insurance policy in the amount equal to or greater than that required by the California Education Code Section 32220-24 and 35330-31 for medical and hospital expenses resulting from accidental bodily injury while participating in or practicing for, interscholastic events or while being transported to and from such events.

Medical/ Health Insurance Company _____ Type of Insurance (i.e. PPO or HMO) _____

Policy Number _____

NOTE: Your attention is directed to the fact that many insurance companies exclude tackle football. Please read your policy, you may need additional insurance.

I also agree to indemnify and hold harmless Cardinal Newman High School from any and all responsibility arising out of, or in any way related to, the requirement under the aforementioned code section to provide insurance coverage for the above name student.

Parent Signature: _____ Date: _____

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height _____ Weight _____	☐ Male ☐ Female	
BP _____ / _____ (_____ / _____) Pulse _____	Vision R 20/ _____ L 20/ _____	Corrected ☐ Y ☐ N
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

  Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO