

**BOSQUE SCHOOL  
STUDENT MEDICAL HISTORY  
2009 - 2010**

(To be completed by parent/guardian)

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_

The following questions deal with the medical history of the student-athlete and his/her family. Please circle the appropriate answer to the following questions and provide detail in the space provided.

- Yes No Diabetes \_\_\_\_\_
- Yes No Epilepsy \_\_\_\_\_
- Yes No Heart trouble \_\_\_\_\_
- Yes No High blood pressure \_\_\_\_\_

Please answer the following questions with regard to the student only. Do you or have you ever had any of the following? If so, please explain in the space provided below.

- |     |    |                                  |     |    |                          |
|-----|----|----------------------------------|-----|----|--------------------------|
| Yes | No | Allergies                        | Yes | No | Asthma                   |
| Yes | No | Hay fever                        | Yes | No | Hepatitis                |
| Yes | No | Bee sting reaction               | Yes | No | Mononucleosis            |
| Yes | No | Pneumonia                        | Yes | No | Medication reaction      |
| Yes | No | Concussion/Loss of consciousness | Yes | No | Dizziness/Faintness      |
| Yes | No | Frequent headaches/Migraines     | Yes | No | Vision problems          |
| Yes | No | Hernia                           | Yes | No | Kidney problems          |
| Yes | No | Menstrual problems (girls)       | Yes | No | Loss of testicles (boys) |
| Yes | No | Skin infections                  | Yes | No | Wear glasses/contacts    |
| Yes | No | Wear dental appliances           | Yes | No | Hearing loss             |
| Yes | No | Wear orthotics/joint brace       |     |    |                          |

Please give injury/condition dates and, if appropriate, indicate left or right side. If you answer yes to any question, please explain in space provided:

- |     |    |                               |     |    |                                 |
|-----|----|-------------------------------|-----|----|---------------------------------|
| Yes | No | Osgood-Schlatter disease      | Yes | No | Growth plate injuries           |
| Yes | No | Recent growth spurts          | Yes | No | Shoulder injuries               |
| Yes | No | Fractures within past 3 years | Yes | No | Elbow/arm injuries              |
| Yes | No | Hand/wrist injuries           | Yes | No | Back injuries/pain              |
| Yes | No | Head injuries                 | Yes | No | Leg/hip injuries                |
| Yes | No | Knee injuries/damage          | Yes | No | Ankle/foot injuries             |
| Yes | No | Metal implants                | Yes | No | Surgery within the past 3 years |

- Yes No Has a physician ever advised you not to participate in sports?
- Yes No Are you currently taking any medications? (If yes, specify medications and reasons)
- Yes No Are you prone to any conditions in athletics? (blisters, shin splints, etc.)
- Yes No Other medical conditions

EXPLAIN ANY YES ANSWERS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

All of the above questions have been answered completely and truthfully to the best of my knowledge.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**BOSQUE SCHOOL  
STUDENT MEDICAL EXAM  
2009-2010**

(To be completed by student's *physician*)

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Eyes uncorrected R20/\_\_\_ L20/\_\_\_

Eyes corrected R20/\_\_\_ L20/\_\_\_

**PHYSICAL EXAM**

|                 | NORMAL | ABNORMAL | COMMENTS |
|-----------------|--------|----------|----------|
| EENT            |        |          |          |
| Cardiovascular  |        |          |          |
| Abdomen         |        |          |          |
| Hernia          |        |          |          |
| Genitalia       |        |          |          |
| Musculoskeletal |        |          |          |
| Neurological    |        |          |          |
| Deformities     |        |          |          |
| Surgical scars  |        |          |          |
| Skin            |        |          |          |
| Urinalysis      |        |          |          |

Medications taking: \_\_\_\_\_

Comments: \_\_\_\_\_

I certify that I have on this date reviewed the above history and examined this individual and find him/her physically able to participate in physical activity sports as indicated below:

- \_\_\_\_\_ Cleared for all activity
- \_\_\_\_\_ Cleared for all activity with the following exceptions \_\_\_\_\_
- \_\_\_\_\_ Not cleared for \_\_\_\_\_

**IMMUNIZATION RECORD** (*New Students must attach a copy of official documentation for previous immunizations—Returning students must attach any immunization updates*)

Are immunizations current?  YES  NO

If no, please comment (i.e. HepB in process—1 of 3 doses thus far—final two doses scheduled):

\_\_\_\_\_

(*Students are not allowed to attend classes without a current immunization record on file*)

**Licensed Medical Physician's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_