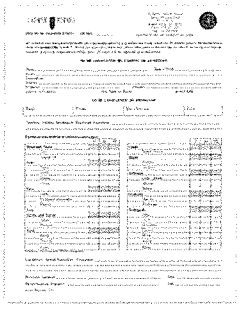
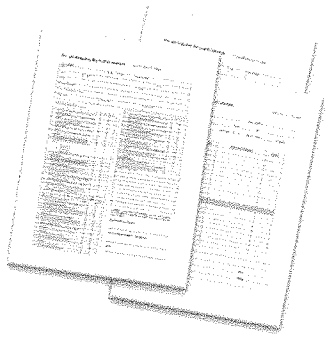
All Saints Required Physicals



The Diocese of Tulsa requires All Saints students to have a physical on file before the first day of every odd grade (PK, 1st, 3rd, 5th, 7th). Additionally *any new student to the school in any grade* must have a physical on file before the first day of school (or within 30 days if they are transferring in the middle of a school year). **All physicals must be completed on the diocesan physical form, no exceptions.** The sports physical form no longer satisfies the school's physical form requirement.

If your son/daughter is interested in playing sports for the school, they must also have a **sports physical** on file, on the three-page diocesan sports physical form, no exceptions. This is mandatory for all players in grades 5th through 8th grades (and for 4th graders who play up on a 5th grade team). Deadlines for sports physicals vary, but it if your student is in grades 5th or 7th and plan to play sports they are already required to have their school physical done before the first day of school, so we suggest taking a copy of BOTH forms as they are BOTH required by the diocese.



For questions regarding the school physical contact the office.

Thank you,

Megan Blakley
All Saints Secretary
mblakley@allsaintsba.com
918-251-3000 phone
918-258-9879 fax

All forms can be found:
http://www.allsaintsba.com/
DownloadableForms.html

For questions regarding the sports physical contact the Athletic Director.

Thank you,

Penny Patton
All Saints P.E. Teacher
& Athletic Director
ppatton@allsaintsba.com
918-251-1125 direct line

Diocesan Middle School
Athletic Association (DMSAA)
http://www.tulsacatholicsports.com/

TULSA DIOCESE
CATHOLIC SCHOOLS

PHYSICAL EXAMINATION – GRADE _____

All Saints Catholic School
School Physical Form
299 S. 9th St.
Broken Arrow, OK 74012
Phone: 918-251-3000
Fax: 918-258-9879
Required for any new student in any grade.

All students must have a current health/physical examination by a qualified physician within six (6) months prior to the entrance of a child into **grades PK, 1, 3, 5, 7**. This form must be on file in the school office prior to the first day of school. In the case of transfer students, a physical examination within thirty (30) days will be required upon admission.

TO BE COMPLETED BY PARENT OR GUARDIAN

Name _____ Date of Birth _____
Sports _____
Medications _____
Injuries _____
Surgeries _____ Allergies _____
Glasses or Contacts _____ Oral Plates or Braces _____ Absent teeth _____

TO BE COMPLETED BY PHYSICIAN

Height	Weight	Blood Pressure	Pulse

Nutrition / General Appearance / Emotional Adjustment _____
_____

Explain any abnormalities in Limitations section below

	N	Ab	NE
Head and Neuro			
Skin			
Cranial NS			
Eyes			
Pupils			
EOMs			
Fundus			
Vision			
Ears			
Canal			
Tympanic Membrane			
Hearing			
Nose			
Mouth and Throat			
Caries			
Pharynx			
Neck			
Pulses			
Thyroid			
Nodes			

	N	Ab	NE
Lungs			
Breath Sounds			
Heart			
Rhythm			
Murmur			
Abdomen			
Liver / Spleen			
Masses			
Hernia			
Genitalia			
Masses			
Discharge			
Orthopedic			
Neck			
T/L/S			
Shoulders			
Elbows			
Wrists			
Ankles			
Knees			

N=Normal, Ab=Abnormal, NE=Not Examined

Limitations / Special Conditions / Comments: _____
_____
_____

Physician Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Forms/Physicals, 3/02

Pre-participation 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:			
Relationship	*Phone (H)*		*Phone (W)*

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

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have an ongoing medical condition (like diabetes, asthma)?		
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicine or pills?		
4. Do you have allergies to medicines, pollens, foods, or stinging insects?		
5. Have you ever passed out or nearly passed out DURING exercise?		
6. Have you ever passed out or nearly passed out AFTER exercise?		
7. Does your heart race or skip beats during exercise?		
8. Does your heart race or skip beats during exercise?		
9. Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection		
10. Has a doctor ever ordered a test for your heart? (i.e., ECG, echocardiogram)		
11. Has anyone in your family died for no apparent reason?		
12. Does anyone in your family have a heart problem?		
13. Has any family member or relative died of heart problems or of sudden death before age 50?		
14. Does anyone in your family have Marfan syndrome?		
15. Have you ever spent the night in a hospital?		
16. Have you ever had surgery?		
17. Have you ever had an injury like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game? If yes, circle affected area below:		
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:		
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:		
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?		
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?		
22. Do you regularly use a brace or assistive device?		
23. Has a doctor ever told you that you have asthma or allergies?		
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
25. Is there anyone in your family who has asthma?		
26. Have you ever used an inhaler or taken asthma medicine?		
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?		
28. Have you had infectious mononucleosis (mono) within the last month?		
29. Do you have any rashes, pressure sores, or other skin problems?		
30. Have you had a herpes skin infection?		
31. Have you ever had a head injury or concussion?		
32. Have you been hit in the head and been confused or lost your memory?		
33. Have you ever had a seizure?		
34. Do you have headaches with exercise?		

	Yes	No
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
36. Have you ever been unable to move your arms or legs after being hit or falling?		
37. When exercising in the heat, do you have severe muscle cramps or become ill?		
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
39. Have you had any problems with your eyes or vision?		
40. Do you wear glasses or contact lenses?		
41. Do you wear protective eyewear, such as goggles or a face shield?		
42. Are you happy with your weight?		
43. Are you trying to gain or lose weight?		
44. Has anyone recommended you change your weight or eating habits?		
45. Do you limit or carefully control what you eat?		
46. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
47. Have you ever had a menstrual period?		
48. How old were you when you had your first menstrual period?		
49. How many periods have you had in the last 12 months?		

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:

Pre-participation Physical Evaluation

PHYSICAL EXAM

Name _____ *Date of Birth* _____

Height _____ *Weight* _____ *Pulse* _____ *BP* _____

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

Medical	Normal	Abnormal Findings	Initials
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin			
MUSCULOSKETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

Notes: _____

_____

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

Address _____ **Phone** _____

Signature of Physician _____,
MD or DO

Pre-participation Physical Evaluation CLEARANCE FORM

Name	*Sex*	*Age*	*Date of Birth*

☐ Cleared without restriction.

☐ Cleared with recommendations for further evaluation or treatment for: _____

_____

_____

☐ Not cleared for ☐ All sports ☐ Certain sports: _____ Reason: _____

Recommendations: _____

_____

EMERGENCY INFORMATION

Allergies _____

Other information _____

IMMUNIZATIONS (e.g., tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

☐ Up to date (see attached documentation) ☐ Not up to date Specify _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO