Tantasqua Regional High School

Brimfield + Brookfield + Holland + Sturbridge + Wales
DEPARTMENT OF ATHLETICS
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Intramural, Interscholastic and/or Routine Grade 11 Physical Examination Form

Student-Athlete's Name: _____ Grade: _____

Address: _____ Phone: _____

Family History

Any close relative(s) with premature myocardial infarction or sudden death at <50 years? Y__ N__
Any family history of Cardiomyopathy , Coronary Artery Disease, Marfan Syndrome, Long QT Syndrome, Severe Arrhythmias or other disabling cardiovascular diseases? Y__ N__
If yes, please explain:

Personal History

History of fainting, passing out, or nearly passing out? Y__ N__
Exertional chest pain or discomfort? Y__ N__
Shortness of breath or fatigue out of proportion to the degree of physical effort? Y__ N__
Palpations or irregular heartbeat? Y__ N__
Any injury requiring medical attention? Specify: Head ____ Neck _____ Extremity ____
Explain _____
Any illness requiring a Doctor's care now? Y __ N__
Medication? Y__N__ If Yes, name of medication. _____
Loss of function or absence of an eye? Y __ N __ Wears Glasses _____ Contacts _____
Any of the following conditions requiring medical care? Heart Condition ___ Blood Disorder ___ Seizures ___
Kidney Disorder __Diabetes __ Allergy __ Requires EPI-PEN ____ May self carry EPI-PEN ____ Y__ N___
Please Explain. _____
History of any surgery? Y __ N __ Reason_____
Do you know of any reason why this student should NOT play all sports? Y__ N___
Please explain any "YES" answers with date, MD name and hospital used. _____

Note – A Physical Exam Form must be on file in the Health Office prior to participation on a team and must remain current through the chosen sport season. Exams should be scheduled for after June 1st preceding the school year concerned. An 11th grade physical is required by law.

I give the above named student permission to participate in the school sponsored physical exam.

_____ _____
Signature Parent/Guardian **Date**

**************************************The following information is to be completed by one's physician**************************************

Postural Screen (9th grade only) _____

B/P_____Pulse_____ Height_____ Weight_____ Hernia _____ Scrotal _____Td _____
Referral _____

On the basis of this examination and the medical history supplied to me by the parent/guardian, I certify this student for supervised school athletic activities of his/her choice, EXCEPT FOR THE REFERRAL MADE ABOVE.

_____ OR _____
Signature of Physician Date Signature of Nurse Practitioner/stamp