Quincy Public Schools
Department of Athletics
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MIAA Recommended Sports Candidate Medical Questionnaire

1. ***PART A IS TO BE COMPLETED AND SIGNED BY PARENT OR GUARDIAN.***
2. ***PART B IS TO BE COMPLETED AND SIGNED BY THE EXAMINING PHYSICIAN.***
3. ***COMPLETED FORM IS TO BE TURNED INTO THE HEALTH OFFICE OF THE PARTICIPATING HIGH SCHOOL.***

PART A: TO BE COMPLETED BY PARENT OR GUARDIAN DATE: _____

Student's Name _____

Student's Address _____ Date of Birth _____

Parent's/Guardian's Name_____ Telephone ( ) _____

Physician Name _____ Telephone ( ) _____

Physician Address _____

Telephone ( ) _____ Name of Insurance _____ Policy # _____

1. When did your child last see a medical doctor in the past two years?

   EXPLAIN: _____

2. Does/has your child have/had a disease(s) that affects the function of eye, ear, testicle, kidney, or lung? If so, please explain? _____

   _____

3. List any operations, fractures, sprains, or bone dislocations:

   _____ DATE OR AGE _____
   _____ DATE OR AGE _____
   _____ DATE OR AGE _____

4. Has your child ever had any of the following? **Circle** ***Y FOR YES,*** ***N FOR NO.***

A. ASTHMA AND/OR ALLERGIES	Y	N	K. MONONUCLEOSIS	Y	N
B. FAINTING AND/OR CONVULSION	Y	N	L. PNEUMONIA	Y	N
C. HEART MURMUR/HEART CONDITION	Y	N	M. HEPATITIS	Y	N
D. RHEUMATIC FEVER	Y	N	N. BRONCHITIS	Y	N
E. KIDNEY DISEASE OR INJURY	Y	N	O. HEAD INJURY	Y	N
F. HEAT STROKE/HEAT EXHAUSTION	Y	N	P. CONCUSSION	Y	N
G. DIABETES	Y	N	Q. SEIZURE	Y	N
H. MENSTRUAL PROBLEMS	Y	N	R. MAJOR DENTAL PROBLEMS	Y	N
I. BLOOD DISORDERS	Y	N	S. TUMORS	Y	N
J. ARTHRITIS AND/OR JOINT REDNESS	Y	N	T. BRIDGES OR FALSE TEETH	Y	N

Any other serious illness or injury? _____

Please explain any "Yes" answers to the above questions: _____

_____

5. Does your child take any medications now? _____ If so, what?

6. Does your child wear glasses or contact lenses? Yes _____ No _____

7. Do you know any reason for your child not to participate in any sports? Yes _____ No _____
IF "**YES**", **PLEASE EXPLAIN** _____
_____ _____

PARENT/GUARDIAN'S SIGNATURE _____ DATE _____

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PART B: ***TO BE COMPLETED BY EXAMINING PHYSICIAN (PLEASE PRINT)***

Name of Student _____

1. Grade _____ 2. Age _____ 3. Height _____ 4. Weight _____ 5. Blood Pressure _____

6. Significant Past Illness or Injury _____ DATE _____
DATE _____
DATE _____
DATE _____

7. Eyes R20/____ L20/____ 8. Ears Hearing R____/15 L____/15

9. Respiratory _____

10. Cardiovascular _____

11. Liver _____ 12. Other_____ 13. Other _____

14. Musculoskeletal _____ 15. Skin _____

16. Neurological _____ 17. Genitalia _____

18. Laboratory: Urinalysis _____ 19. Other _____

Comments: _____

_____

20. Recommendations for participation with the following restrictions: _____

_____

21. Date of Last Physical Examination: _____
22. Tetanus booster within the past ten years? YES_____ NO _____ Date: _____

Name of Physician (please print) _____

Practice Name/Address:_____ Telephone ( ) _____

Physician's Signature _____ Date: _____