Ambassador Preparatory/IAM
325 Dayton Avenue, St. Paul, MN 55102

Physical Examination Form
(Junior Boarding only)

Student Name____ Date of Examination___/___/___
Date of Birth ___/___/___

History
Circle Yes(Y) or No (N)
1. Have you ever fainted during or after practice? Y/N
Have you had chest pain during exercise? Y/N
2. Family history of sudden death? Y/N
Before age 35? Before age 50?
3. Have you ever had a concussion? Y/N
Have you ever had loss of consciousness? Y/N
Have you ever had a head injury? Y/N
How many? ___
4. Have you ever had heat stroke, heat exhaustion, or passed out from heat? Y/N
5. Do you wheeze or cough during or after exercise? Y/N
6. Do you have any allergies? (Medications, bee sting, pollens, other ____________________) Y/N
7. Any injuries or illness since last exam? Y/N
List: ________________________________ Y/N
8. Have you been ill in the last month? Y/N
9. Have you ever been hospitalized? Y/N
Have you ever had surgery? Y/N
If yes, explain: ____________________________
____
10. Immunization:
Last DT Month ____ Day ____ Year____
Last MMR Month ____ Day ____ Year____
11. Have you had: (circle)

abnormal bleeding	anemia	sprain
abnormal bruising	diabetes	dislocation
broken bones	seizures	vision loss
stress fractures	scoliosis	stinger
heart murmur	palpitations	
rheumatic fever	hearing loss	
single organ	sickle cell disease	
hepatitis	high blood pressure	
eye loss	undescended testicle	

12. Do you use any special equipment? Y/N
13. Are there other concerns you have? Y/N
14. List any medications or pills you take (including over-the-counter, vitamins, supplements) _____________
____
____

Physician signature Date
____
Clinic/Address ________________________________
____
Phone number ________________________________

Physical Examination

Ht _____ Wt_____ BP____/____
Vision R 20/_____ L 20/_____
Anisocoria Y/N

Glasses	Y/N
Contact Lens	Y/N
Eye Protection	Y/N
Mouthguard	Y/N

HEENT		**Notes**
Fundoscopic	Nrl/Abnrl	____________
Ears	Nrl/Abnrl	____________
Mouth	Nrl/Abnrl	____________
Throat	Nrl/Abnrl	____________
Dental	Nrl/Abnrl	____________
Thyroid	Nrl/Abnrl	____________
Lymph nodes	Nrl/Abnrl	____________
Lungs	Nrl/Abnrl	____________
Heart	Nrl/Abnrl	____________
Murmur	Nrl/Abnrl	____________
Abdomen	Nrl/Abnrl	____________
Genitalia	Nrl/Abnrl	____________

Tanner stage (optional) I II III IV V
Hernia Y/N
Skin Nrl/Abnrl
Body Fat % (optional) ________

Musculoskeletal

Neck	Nrl/Abnrl	Quad/ham	Nrl/Abnrl
Shoulder	Nrl/Abnrl	Ankle	Nrl/Abnrl
Elbow	Nrl/Abnrl	Feet	Nrl/Abnrl
Hands	Nrl/Abnrl	Heel/Toe	Nrl/Abnrl
Back	Nrl/Abnrl	Duck walk	Nrl/Abnrl

Immunizations given today: ______________________
____

Notes: ______________________________________
____
____
____
____

I do not know of any existing physical or additional health reason that would preclude participation in sports. I certify that the answers to the above questions are true and accurate. I approve participation in athletic activities. I hereby authorize release to the school nurse, trainer, coach, and medical providers of the information contained in this document. Upon written request, I may receive a copy of this document for my personal health care provider.

Parent or legal guardian signature Date
____

Athlete signature Date

SPORTS CLEARANCE/IMMUNIZATIONS

Student Name:____ Birth date _________________ Age:______ Gender ______

Address: ____

Home Telephone: _____________________________________

Sports: ____

I certify that the above student has been medically evaluated and is deemed to by physically fit to participate in school interscholastic activities as indicated below.

Participation clearance for:

Collision sports	Yes/No
Contact sports	Yes/No
Non-contact sports	Yes/No

If No, due to: ____

Further evaluation required: ____

Modifications or exceptions; ____

Attending Physician (signature) ____ Date ________________

Print Name ____ Phone # ____________________________

Valid for 3 years from above date with a normal Annual Health Questionnaire (All No responses) Year 2 Year 3

Sports Classification

Collision and/or Contact Sports		Non-contact Sports
Baseball Basketball Cheerleading Volleyball Football Wrestling Field events high jump pole vault	Soccer Softball Hockey Swimming	Dance Golf Tennis Track and Field discus javelin shot put

Immunization Record

Diphtheria- Tetanus- Pertusis	_______	_______	_______	_______	_______	
Diphtheria-Tetanus	_______	_______ (mo/ day/ yr)				
Oral Polio	_______	_______	_______	_______ (mo/ day/ yr)		
Rubeola	_______	_______ (mo/ day/ yr) must be given after 1st birthday				
Mumps	_______	_______ (mo/ day/ yr)				
Rubella	_______	_______ (mo/ day/ yr)				
Hepatitis B	________	_______	_______ (mo/ day/ yr)			
Varicella	________	_______ (mo/ day/ yr)				

** The Minnesota State Health Department requires that all immunizations be up to date or the student may not attend school. **