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 OFFCE 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 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 _____

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
				U.	OTHER	Y	N

** * If student was diagnosed with a **concussion**, please list diagnosis and duration of symptoms

_____

Please explain any "Yes" answers to the above questions

_____

_____

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

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

_____

7. **I have read and understand the CDC's Parent/Athlete Information Sheet on Concussion provided**.

PARENT/GUARDIAN'S SIGNATURE _____ DATE _____

STUDENT/ATHLETE 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 _____