Fax (617) 376-1236

MIAA Recommended Sports Candidate Medical Questionnaire

2. PART BIS TO BE COMPLETED AND SIGNED BY THE EXA 3. COMPLETED FORM IS TO BE TURNED INTO. THE HEALTH HIGH SCHOOL.	
PART A: TO BE COMPLETED BY PARENT OR GU	IARDIAN DATE:
Student's Name	
Student's Address	Date of Birth
Parent's/Guardian Name	Telephone ()
Physician Name_·	Telephone ()
Physician Address	
Physician Address Telephone () Name of Insura	ance Policy#
1. When did your child last see a medical doctor in t	he past two years? •
EXPLAIN:	
2 Does/has your child have/had a disease(s) that a lung? If so, please explain?	ffects the function of eye, ear, testicle, kidney, or
3. List any operations; fractures, sprains; or bone dis	slocations DATEORAGE
3. List any operations; fractures, sprains; or bone dis	* ,
3. List any operations; fractures, sprains; or bone dis	* ,
3. List any operations; fractures, sprains; or bone dis	* ,
3. List any operations; fractures, sprains; or bone dis	Circle y FOR YES, N FOR NO, N K MONONUCLEOSIS Y N N L PNEUMONIA Y N N M. HEPATITIS Y N N N BRONCHITIS Y N N **0. HEAD INJURY Y N N **P. CONCUSSION, Y N N **P. CONCUSSION, Y N N Q. SEIZURE Y N N R MAJOR DENTAL PROBLEMS Y N N S. TUMORS Y N N T. BRIDGES OR FALSE TEETH Y N U. OTHER Y

5. Does your child take any medications now?	If so, what?
6. Do you know any reason for your child not to parti- IF "YES", PLEASE EXPLAIN:	cipate in any sports? Yes No
7. I have read and understand the CDC's Parent/A	Athlete Information Sheet on Concussion provided
PARENT/GUARDIAN'S SIGNATURE	DATE
STUDENT/ATHLETE SIGNATURE	DATE
******************	*_**********************
PARTB: TO BE COMPLETED BY EXAMINING PH	YSICIAN (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	II
11. Liver 12. Other	
14. Musculoskeletal	15. Skin
16. Neurological	17. Genitalia
18. Laboratory: Urinalysis	19. Other
Comments	<u> </u>
20. Recommendations for participation with the follow	ing restrictions
21. Date of Last Physical Examination	* ************************************
22. Tetanus booster within the past ten years?	S Date: Date:
Name of Physician (please print)	
Practice Name/Address	Telephone ()
Physician's Signature	Date

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