Wahkiakum School District

Record of Physical Examination

This physical examination is intended to evaluate individuals for safe participation in sports.

Last name: ____________________ First: ____________________

Address: ____

Phone: ____________________ Birthdate: ____________________

Work Phone: ____________________ or ____________________

Family Doctor: ____________________ Phone: ____________________

Preferred Hospital: ____

Emergency Contact: ____________________ Phone: ____________________

Medicines taken regularly: Allergies to Medicine:

Parent Comments

(From Previous Page)

Item # Comment

Insurance

To participate in interscholastic athletics students must have insurance or purchase school accident coverage.

Do you have insurance? Yes__________ No__________

Name of Insurance Company ______________________________

Policy Number ______________________________

(must have policy number to be valid)

In Case of Emergency

In the event of a serious injury, either at school or away from school, does the Coaching Staff have your permission to seek medical treatment for your athlete?

Yes__________ No__________

If not, what procedure would you like the Coaches to follow?

Parent/Guardian ______________________________
Signature

Please notify the school if any information on this page changes.

Wahkiakum School District

Medical History

Please review this information with a parent or guardian
Also, provide additional information for all items marked yes on reverse side.

Yes	No	
___	___	1. Have you had any illness/injury recently, or do you have an illness/injury now?
___	___	2. Have you had a medical problem, illness or injury since your last exam?
___	___	3. Do you have any chronic or recurrent illness?
___	___	4. Have you ever had any illness lasting more than a week?
___	___	5. Have you ever been hospitalized overnight?
___	___	6. Have you had any surgery other than tonsillectomy?
___	___	7. Have you ever had any injuries requiring treatment by a physician?
___	___	8. Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc.)?
___	___	9. Are you presently taking ANY medications (including birth control pills, vitamins, aspirin, etc.)?
___	___	10. Do you have ANY allergies (medicines, bees, foods, or other factors)?
___	___	11. Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?
___	___	12. Do you tire more easily or quickly than your friends during exercise?
___	___	13. Have you ever had any problem with your blood pressure or your heart?
___	___	14. Has any close relative had heart problems, heart attack or sudden death before they were age 50?
___	___	15. Do you have any skin problems (acne, itching, rashes, etc.)?
___	___	16. Have you ever had fainting, convulsions, seizures or severe dizziness?
___	___	17. Do you have frequent severe headaches?
___	___	18. Have you ever had a "stinger" or "burner" or "pinched nerve"?
___	___	19. Have you ever been "knocked out" or "passed out"?
___	___	20. Have you ever had a head or neck injury?
___	___	21. Have you ever had heat exhaustion, heat stroke, heat cramps, or similar heat-related problems?
___	___	22. Have you had asthma, or trouble breathing, or cough during or after exercise?
___	___	23. Do you wear eyeglasses, contact lenses or protective eye wear?
___	___	24. Have you had any problem with your eyes or vision?
___	___	25. Do you wear any dental appliance such as braces, bridge, plate, retainer?
___	___	26. Have you ever had a knee injury?
___	___	27. Have you ever had an ankle injury?
		28. Have you ever injured any other joint (shoulder, wrist, finger, etc.)?
___	___	29. Have you ever had a broken bone (fracture)?
___	___	30. Have you ever had a cast, splint, or had to use crutches?
___	___	31. Must you use special equipment for competition (pads, braces, neck roll, etc.)
___	___	32. Has it been more than 5 years since your last tetanus booster shot?
___	___	33. Are you worried about your weight?
___	___	34. FEMALES: Have you any menstrual problems?
___	___	35. Have you any medical concerns about participating in your sport?

Physical Exam

Last Name:____________________ First:____________________
Age:____________ Pulse:____________
Height:____________ Blood Pressure:____________
Weight:____________ Visual Acuity: Left 20/________ Right 20/________

Normal		Abnormal	Comment
______	1. Head	______	______________
______	2. Eyes (pupils) ENT	______	______________
______	3. Teeth	______	______________
______	4. Chest	______	______________
______	5. Lungs	______	______________
______	6. Heart	______	______________
______	7. Abdomen	______	______________
______	8. Genitalia	______	______________
______	9. Neurologic	______	______________
______	10. Skin	______	______________
______	11. Physical Maturity	______	______________
______	12. Spine, Back	______	______________
______	13. Shoulders, Upper Extremities	______	______________
______	14. Lower Extremities	______	______________

Assessment: ________ Full Participation
________ Limited Participation (describe restrictions)
________ Not eligible for athletics at this time

Examiner's Comments ______________________________
____
____

Date:____________

Examiner:____________________
Examiner's name (printed):____________________
Examiner's Phone:____________________