

Wahkiakum School District

Record of Physical Examination

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

Last name: _____ First name: _____

Address: _____

Phone: _____ Birthdate: _____

Work phone: _____ OR _____

Family Doctor: _____ Phone: _____

Preferred Hospital: _____

Emergency Contact: _____ Phone: _____

Medicines Taken Regularly

Allergies to Medicine

_____	_____
_____	_____
_____	_____

Parent Comments

(From YES answers in the Medical History on Page2)

Item #	Comment
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Insurance

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

Do you have insurance?

No → Must purchase school accident coverage

Yes → 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 → What procedure(s) would you like the Coaches to follow?

Parent/Guardian Must Sign This Form

Signature: _____

Print Name: _____

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 page 1.

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

Physical Exam

Last name: _____ First name: _____

Age: _____

Height: _____

Weight: _____

Pulse: _____

Blood Pressure: _____

Visual Acuity: Left: 20/ _____ Right: 20/ _____

Normal	Abnormal	Comment
<input type="checkbox"/> 1. Head	<input type="checkbox"/>	_____
<input type="checkbox"/> 2. Eyes (pupils) ENT	<input type="checkbox"/>	_____
<input type="checkbox"/> 3. Teeth	<input type="checkbox"/>	_____
<input type="checkbox"/> 4. Chest	<input type="checkbox"/>	_____
<input type="checkbox"/> 5. Lungs	<input type="checkbox"/>	_____
<input type="checkbox"/> 6. Heart	<input type="checkbox"/>	_____
<input type="checkbox"/> 7. Abdomen	<input type="checkbox"/>	_____
<input type="checkbox"/> 8. Genitalia	<input type="checkbox"/>	_____
<input type="checkbox"/> 9. Neurologic	<input type="checkbox"/>	_____
<input type="checkbox"/> 10. Skin	<input type="checkbox"/>	_____
<input type="checkbox"/> 11. Physical Maturity	<input type="checkbox"/>	_____
<input type="checkbox"/> 12. Spine, Back	<input type="checkbox"/>	_____
<input type="checkbox"/> 13. Shoulders, Upper Extremities	<input type="checkbox"/>	_____
<input type="checkbox"/> 14. Lower Extremities	<input type="checkbox"/>	_____

Assessment (select one option)

- Full Participation Limited Participation (describe restrictions)
- NOT Eligible for Athletics at This Time

Examiner's Comments _____

Date: _____ Examiner Signature: _____

Examiner Name Printed: _____

Examiner's Phone #: _____