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	
☐	☐	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 a 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, 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 quicldy than your friends during exerclse ?
☐	☐	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, p1ate, 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 participatlng in your sport?

Physical Exam

Last name: _____ First name: _____

Age: _____

Height: _____ Weight: _____

Pulse: _____ Blood Pressure: _____

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 Extremeties	☐	_____

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 #: _____