Central Kitsap School District

INITIAL PHYSICAL EXAMINATION FOR ATHLETIC COMPETITION

TO BE COMPLETED BEFORE ENTRY INTO ATHLETICS

Name: _____ **Visual Acuity: L 20/_____ R 20/_____**

Height: _____ **Weight:** _____ **With/Without Correction**
Contact Lenses (circle one) Y N

Blood Pressure (Sitting, Rt. Arm): _____

Pulse: Resting pulse _____
Lab*: Hct _____ **Sickle Cell** _____
Urinalysis*: Protein _____ **Sugar** _____ **Blood** _____
***Optional (Urinalysis needs parent authorization.)**

General Appearance/Somatotype: _____ **Abdomen:** _____

Eyes: E.O.M._____ **Genitalia:** _____ ☐ **Not examined**

Pupils: _____ **Skin:** _____
Ears/Nose/Throat: _____

Other Remarks: _____
Dental/Braces: _____

Lymph Nodes: _____

Strength:_____
Cardiac: Murmur: Yes _____ **No** _____
Pulse: Regular _____ **Irregular** _____

Respiratory: _____ **Flexibility:** _____

Posture/Neck/Back/Scoliosis: _____

General Conditioning: _____
Upper Extremities: _____

Lower Extremities: _____

DISPOSITION AND RECOMMENDATIONS (USE BACK OF FORM FOR ADDITIONAL INFORMATION)

DIAGNOSIS OR PROBLEM	TREATMENT RECOMMENDATIONS
1) _____	_____
2) _____	_____
3) _____	_____

DISPOSITION: _____ **1) Unrestricted activity in high school sports grades 9-12**

_____ **2) Unrestricted activity in any sport grades 6-8**

_____ **3) Unrestricted activity in all sports except** _____

_____ **4) No participation until** _____

_____ **5) Conditional participation, limited to** _____

_____ **6) No participation in any sport**

_____ _____ _____
Date **Doctor's Signature** **Phone**

HEALTH HISTORY FORM FOR ATHLETIC COMPETITION

TO BE COMPLETED BEFORE VISIT TO HEALTH PROFESSIONAL

Date: _____ **School:** _____

Student's Name: _____ **Notify in emergency:** _____

Address: _____ **Address:** _____

Phone: _____ **Phone:** _____

Birth Date: _____ **Age:**_____ **Grade:** _____ **Family Doctor:** _____

Date of last tetanus booster: _____ **Phone:** _____

(Circle One) Left Handed Right Handed

PLEASE CHECK ONE ANSWER	**YES**	**NO**
Has anyone in your family under age 50 died suddenly?	☐	☐
Have you had or do you now have brain concussion (head injury)?	☐	☐
Tendency to lose consciousness (faint)?	☐	☐
Skull Fracture?	☐	☐
Convulsions or epilepsy?	☐	☐
Neck injury?	☐	☐
Headaches?	☐	☐
Have you had or do you now have very bad (impaired) vision in one eye?	☐	☐
Temporary loss of vision?	☐	☐
Do you wear glasses or contact lenses?	☐	☐
Have you had or do you now have hearing loss?	☐	☐
Perforated ear drum?	☐	☐
Discharge from ear (recurrent infections)?	☐	☐
Sinus infections?	☐	☐
Broken nose?	☐	☐
Dental Plate (dentures)?	☐	☐
Removable retainer?	☐	☐
Have you had or do you now have a hernia?	☐	☐
Kidney problems (or absence of)?	☐	☐
Boys: Problem with testicles?	☐	☐
Girls: Menstrual problems?	☐	☐
Age of onset of menstruation _____		
Breast lumps or tenderness?	☐	☐
Have you had or do you now have broken bones/cast?	☐	☐
Joint dislocation?	☐	☐
Shoulder injury or recurrent pain?	☐	☐
Elbow injury or recurrent pain?	☐	☐
Back injury or frequent backaches?	☐	☐
Knee injury, recurrent pain or swelling?	☐	☐
Shin splints or recurring leg pain?	☐	☐
Ankle injury or recurrent pain?	☐	☐
Foot problems?	☐	☐

	YES	**NO**
Have you had or do you now have other joint trouble?	☐	☐
Arthritis?	☐	☐
Scoliosis?	☐	☐
Have you had or do you now have diabetes (high sugar in blood or urine)?	☐	☐
Tendency to bleed or bruise easily?	☐	☐
Anemia ("tired blood")?	☐	☐
Mononucleosis?	☐	☐
Liver disease?	☐	☐
Have you had or do you now have Asthma (wheezing)?	☐	☐
Hay fever?	☐	☐
Chest tightness & cough following running?	☐	☐
Hives or rash?	☐	☐
Bee sting reactions (allergy)?	☐	☐
Reaction to medicine (allergy)?	☐	☐
Do you:		
Use alcohol or drugs?	☐	☐
Smoke or chew?	☐	☐
Take any medicine regularly?	☐	☐
If yes, name _____		
Take medicine for emergency use?	☐	☐
If yes, name _____		
Have you had or do you now have heart trouble or murmur?	☐	☐
High blood pressure?	☐	☐
Persistent cough?	☐	☐
Dizziness or faintness with heat?	☐	☐
Cold sores?	☐	☐
Fungus infection?	☐	☐
Athlete's foot?	☐	☐
Recurrent boils (skin infection)?	☐	☐
Have you ever had any other injuries or illness that caused you to miss a game or practice?	☐	☐

ADDITIONAL HISTORY INFORMATION_____

_____

PHYSICIAN'S REMARKS _____

_____

_____

Physician's Signature

I HAVE READ THIS FORM. ALL INFORMATION IS ACCURATE.

_____

Parent Signature Required

Use back of form to provide further information