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):		14	
Pulse: Resting pulse Lab*: Hct Urinalysis*: Protein *Optional (Urinalysis needs pa	Sickle Cell Sugar Blood			
General Appearance/Somatotyp	e:	Abdomen:	-	
Eyes: E.O.M		Genitalia:	□ Not examined	
=				
		Other Remarks:		
Lymph Nodes: No		Strength:		
Pulse: Regular	No _ Irregular			
Respiratory:		Flexibility:		
Posture/Neck/Back/Scoliosis:				
Upper Extremities:		General Conditioning:		
——————————————————————————————————————				
		USE BACK OF FORM FOR ADDITIONAL INFO		
DIAGNOSIS OR PROBLEM		TREATMENT RECOMMENDATIONS		
1)				
2)				
3)				
DISPOSITION:	1) Unrestricted activity in	n high school sports grades 9-12		
	-	2) Unrestricted activity in any sport grades 7-8		
	3) Unrestricted activity in	all sports except		
	4) No participation until _			
	5) Conditional participation	on, limited to		
	6) No participation in any	sport		
	Doctor's S	ignature	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	e:	Family Doctor:
Date of last tetanus booster:		Phone:
PLEASE CHECK ONE ANSWER YES	<u>NO</u>	(Circle One) Left Handed Right Handed $\underline{\underline{YES}} \qquad \underline{\underline{NO}}$
Has anyone in your family under age 50 died. suddenly?		Have you had or do you now have other joint trouble?
Have you had or do you now have		Arthritis?
brain concussion (head injury)?		Scoliosis?
Tendency to lose consciousness (faint)?		Have you had or do you now have diabetes
Skull Fracture?	\equiv	(high sugar in blood or urine)?
Convulsions or epilepsy?	H	Tendency to bleed or bruise easily?
Neck injury?		Anemia ("tired blood")?
Headaches?		Mononucleosis?
Treatactics:		Liver disease?
Have you had or do you now have very bad		Liver disease.
(impaired) vision in one eye?		
Temporary loss of vision?		Have you had or do you now have Asthma
Do you wear glasses or contact lenses?		(wheezing)?
		Hay fever?
Have you had or do you now have		Chest tightness & cough following running?
hearing loss?		Hives or rash?
Perforated ear drum?	\vdash	Bee sting reactions (allergy)?
Discharge from ear (recurrent infections)?		Reaction to medicine (allergy)?
Sinus infections?	-	_
Broken nose?		Do <u>you</u> :
Dental Plate (dentures)?		Use alcohol or drugs?
Removable retainer?		Smoke or chew?
Have you had or do you now have		Take any medicine regularly?
a hernia?		• /
Kidney problems (or absence of)?		Take medicine for emergency use?
Boys: Problem with testicles?		If yes, name
Girls: Menstrual problems?		• /
Age of onset of menstruation		
Breast lumps or tenderness?		Have you had or do you now have heart
**		trouble or murmur?
Have you had or do you now have		High blood pressure?
broken bones/cast?		Persistent cough?
Joint dislocation?		
Shoulder injury or recurrent pain?	-	Cold sores?
Elbow injury or recurrent pain?		Fungus infection?
Back injury or frequent backaches?		Athlete's foot?
Knee injury, recurrent pain or swelling?		Recurrent boils (skin infection)?
Shin splints or recurring leg pain?		Hove you even had one other injuries on illness
Ankle injury or recurrent pain?		Have you ever had any other injuries or illness
Foot problems?		that caused you to miss a game or practice?
ADDITIONAL HISTORY INFORMATION		
		I HAVE READ THIS FORM. ALL INFORMATION IS ACCURATE.
PHYSICIAN'S REMARKS		Parent Signature Required
		Use back of form to provide further information

Physician's Signature

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