SPORTS MEDICAL HISTORY AND EXAMINATION

Name: _____Birth Date: _____ Year of Graduation: _____ M __ F__

Parent/guardian name: _____

Address: _____City: _____State: _____ Zip: _____

Phone: _____ School: _____ Date of Exam: _____Student # _____

Sport(s): (List all): _____

MEDICAL HISTORY

Yes	No	(Please explain all yes answers)
1 ☐	☐	Are you presently taking **any** medication? List: _____
		-- what is the medication taken for?: _____ _____
2 ☐	☐	Do you have any chronic or recurrent medical conditions? _____
3 ☐	☐	Have you had any surgery? _____
4 ☐	☐	Do you have any missing organs other than tonsils (appendix, eye, kidney, testicle, etc.)? _____
5 ☐	☐	Do you have any **allergies/conditions that are life threatening*** or affect school/sports? _____
6 ☐	☐	Have you ever had chest pain, dizziness, fainting, passing out during or after exercise? _____
7 ☐	☐	Have you ever had any problem with your blood pressure or heart? _____
8 ☐	☐	Do you have any skin problems? _____
9 ☐	☐	Have you ever had fainting, convulsions, seizures, or severe dizziness? _____
10 ☐	☐	Have you had asthma or trouble breathing or cough during exercise? _____
11 ☐	☐	Do you wear corrective lenses or protective eye wear? _____
12 ☐	☐	Do you have a significant vision or hearing problem? _____
13 ☐	☐	Do you wear any dental appliance such as braces, bridge, plate, retainer? _____
14 ☐	☐	FEMALES: Have you had any menstrual problems? _____
15 ☐	☐	Do you have any other medical concerns? _____

*** WAC 180-38-045 Attendance of every student at every public school who has a LIFE THREATENING health condition is conditioned upon: Parent presentation of a medication/treatment order, formulation of a nursing plan to implement the order.**

SPORTS/INJURY HISTORY

16 ☐	☐	Have you any medical concerns about participating in your sport? _____
17 ☐	☐	Have you had any injuries requiring treatment by a physician? _____
18 ☐	☐	Have you ever had a knee injury? _____
19 ☐	☐	Have you ever had an ankle injury?_____
20 ☐	☐	Have you ever had a broken bone (fracture)? _____
21 ☐	☐	Have you ever injured any other joint (shoulder, wrist, fingers, etc)? _____
22 ☐	☐	Have you ever had a cast, splint, or had to use crutches? _____
23 ☐	☐	Must you use special equipment for competition (pads, braces, neck roll, etc)? _____
24 ☐	☐	Has it been more than 5 years since your last tetanus booster shot? _____
25 ☐	☐	Have you ever had a neck/head injury? _____ When?_ _____
26 ☐	☐	Have you ever had a heat related problem? (Heat exhaustion, heat stroke) _____

Parents/Students: DO NOT WRITE BELOW THIS LINE

EXAMINER'S COMMENT ON ALL "YES" ANSWERS (refer to number):

_____

_____

_____

_____

_____

STUDENT NAME:_____

PHYSICAL EXAMINATION

Age: ——— Pulse: ——— Height: —— Weight: _____ Blood Pressure: _____ Visual Acuity: Left:20/___ Right: 20/___

Normal	Abnormal		
☐	☐	Head	_____
☐	☐	Eyes (pupils) ENT	_____
☐	☐	Teeth	_____
☐	☐	Chest	_____
☐	☐	Lungs	_____
☐	☐	Heart	_____
☐	☐	Abdomen	_____
☐	☐	Genitalia	_____
☐	☐	Neurological	_____
☐	☐	Skin	_____
☐	☐	Physical Maturity	_____
☐	☐	Spine, Back	_____
☐	☐	Shoulders, upper extremities	_____
☐	☐	Lower extremities	_____

Assessment:

☐ Full participation

☐ Limited participation (describe limitations, restrictions):

_____

_____

☐ Participation contraindicated (list reasons):

_____

_____

Recommendations (equipment, taping, rehabilitation, etc.) _____

_____

DATE: _____ **EXAMINER'S SIGNATURE:** _____

Please Print or Stamp:

PHYSICIAN

Name:

Address:

Phone: