Central Kitsap School District

INITIAL PHYSICAL EXAMINATION FOR ATHLETIC COMPETITION

TO BE COMPLETED BEFORE ENTRY INTO ATHLETICS

Name: ______________________________

Height: ____________ **Weight:** ____________

Blood Pressure (Sitting, Rt. Arm): ____________

Pulse: Resting pulse ____________

Lab*: Hct ____________ **Sickle Cell** ____________

Urinalysis*: Protein ________ **Sugar** ________ **Blood** ________

***Optional (Urinalysis needs parent authorization.)**

Visual Acuity: L 20/________ **R 20/**________

With/Without Correction

Contact Lenses (circle one) Y N

General Appearance/Somatotype: ____________

Eyes: E.O.M. ____________

Pupils: ____________

Ears/Nose/Throat: ____________

Dental/Braces: ____________

Lymph Nodes: ____________

Cardiac: Murmur: Yes _______ **No** _______

Pulse: Regular _______ **Irregular** _______

Respiratory: ____________

Posture/Neck/Back/Scoliosis: ____________

Upper Extremities: ____________

Lower Extremities: ____________

Abdomen: ____________

Genitalia: ____________ ☐ **Not examined**

Skin: ____________

Other Remarks: ____________

Strength: ____________

Flexibility: ____________

General Conditioning: ____________

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 7-8**

________ **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: ____________________

Student's Name: ____

Address: ____

Phone: ____

Birth Date: ________________ Age:________ Grade: ________

Date of last tetanus booster: ________________________________

School: ____

Notify in emergency: ____

Address: ____

Phone: ____

Family Doctor: ____

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

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