North Kitsap School District #400
Pre-participation History and Physical Examination Form

Name: _____ *Birth Date:* _____

Address: _____

City: _____ *Phone:* _____

Zip: _____ *Sport(s):* _____

Grade: _____ *School:* _____

PLEASE EXPLAIN ANY YES ANSWERS BELOW!

HISTORY

	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 over night?
6.	❑	❑	Have you had any surgery other than 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?
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 quickly than your friends during exercise?
13.	❑	❑	Have you ever had any problem with your blood pressure or your heart?
14.	❑	❑	Have any close relatives 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 had been "knocked out" or "passed out"?
20.	❑	❑	Have you ever had a neck or head 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, plate, and 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, fingers, 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 participating in your sport?

Yes Answers _____

_____

_____

PARENT SIGNATURE: _____

PHYSICAL EXAMINATION

Age: _____ Pulse: _____

Height: _____ Blood Pressure: _____

Weight: _____ Visual Acuity: Left 20/_____
Right 20/_____

Normal		Abnormal	
❑	1. Head	❑	_____
❑	2. Eyes (Pupils), ENT	❑	_____
❑	3. Teeth	❑	_____
❑	4. Chest	❑	_____
❑	5. Lungs	❑	_____
❑	6. Heart	❑	_____
❑	7. Abdomen	❑	_____
❑	8. Neurologic	❑	_____
❑	9. Skin	❑	_____
❑	10. Physical Maturity	❑	_____
❑	11. Spine, Back	❑	_____
❑	12. Upper Extremities	❑	_____
❑	13. Lower Extremities	❑	_____
❑	14. Flexibility	❑	_____

Assessment:

❑ **Full Participation**

❑ **Limited Participation (describe limitations, restrictions):**

_____

_____

_____

❑ **Participation contraindicated (list reasons):**

_____

_____

_____

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

_____

Will this physical be acceptable for High School Sports: Yes No (Circle one)

DATE: _____ EXAMINER'S PHONE: ( ) _____

EXAMINER'S SIGNATURE: _____

EXAMINER'S PRINTED NAME: _____

MEDICAL AUTHORITIES LICENSED TO GIVE PREPARTICIPATION PHYSICAL EXAMINATION:

1. Medical Doctor (MD) 2. Doctor of Osteopathy (D.O.) 3. Certified Nurse Practitioner (CRN) 4. Physician Assistant (P.A.) 5. Naturopaths (N.D.)