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: _____

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