NATRONA COUNTY SCHOOL DISTRICT SCHOOL PHYSICAL EXAM FORM

PHYSICIAN'S STATEMENT MUST BE DATED AFTER MAY 1 TO BE VALID FOR THE UPCOMING SCHOOL YEAR

RED Areas Are to Be Completed by Parent and Student Prior to Physical Examination

STUDENT INFORMATION			
School:		Date of Exam:	
Name:		Date of Birth:	
Grade: Gender:	Male Female		
SPECIFIC SPORT YOU WILL BE PAR	TICIPATING: Fall:	Winter:	Spring:
Height: Weight:	% Body Fat (opt.):	Pulse:	BP:
Vision: R 20/ L 20/	Corrected: Yes No	Pupils: Equal _	Unequal
Appearance Eyes/Ears/Nose/Throat Lymph Nodes Heart Pulses Lungs Abdomen Genitilia (males only)	L* ABNORMAL FINDING	SS	
Skin MUSCULOSKELETAL NORMA Neck Back Shoulder/Arm Elbow/Forearm Wrist/Hand	L* ABNORMAL FINDING	SS	
Hip/Thigh Knee Leg/Ankle Foot			
*Normal by check (√) or No			
Cleared *Cleared after completing evaluation	/rehabilitation for:		
Not cleared for : Reason: Recommendations:			
Physician's Name (print/type):		Dat	e:
Address:		Phone:	
Signature of Physician:		☐ MD	□ ро

MEDICAL/HEALTH HISTORY

Please explain "Yes" answers on bottom of page

Y	<u>1</u>	
	1.	Have you ever been hospitalized?
	a.	Have you ever had surgery?
	2.	Are you presently taking any medications or pills?
	3.	Do you have any allergies (medicine, bees or other stinging insects)?
	4.	Have you ever passed out during or after exercise?
	a.	Have you ever been dizzy during or after exercise?
	b.	Have you ever had chest pain during or after exercise?
	c.	Do you tire more easily that your friends during exercise?
	d.	Have you ever had high blood pressure?
	e.	Have you ever been told that you have a heart murmur?
	f.	Have you ever had racing of your heart or skipped heartbeats?
	g.	Has anyone in your family died of heart problems or a sudden death before age 50?
	5.	Do you have any skin problems (itching, rashes, acne)?
	6.	Have you ever had a head injury?
	a.	Have you ever been knocked out, unconscious, or lost your memory?
	b.	Have you ever had a seizure?
	c.	Have you ever had a stinger, burner, pinched nerve, or numbness in extremities?
	7.	Have you ever had heat or muscle cramps?
	a.	Have you ever been dizzy, passed out, or become ill due to heat?
	8.	Do you have trouble breathing or do you cough during or after activity?
	9.	Do you use special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?
	10.	Have you had any problems with your eyes or vision?
	a.	Do you wear glasses or contacts or protective eye wear?
	11.	Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other
		injuries of any bones or joints?
		Head Elbow Shoulder Neck Thigh Knee Foot
		Back Chest Forearm Wrist Ankle Hand Hip Shin/Calf
Y N	V	
	12.	Have you had any other medical problems (asthma, diabetes, mononucleosis, etc.)?
	13.	Have you had a medical problem or injury since your last evaluation?
	14.	When was your first menstrual period?
	a.	When was your last menstrual period?
	b.	What was the longest time between your periods last year?
YN	<u>\</u>	
	15.	Has a physician ever denied or restricted your participation in sports or any physical activity?
Explai	in all "Y	Yes" answers