

WHATCOM COUNTY SPORTS PHYSICAL EXAM

(Required prior to participation in Middle & High Schools – PARENTS MUST REVIEW & SIGN)

Pre-Participation

Returning

Name _____ Birth Date _____ School _____ Exam Date _____

Address _____ City _____ Phone _____

Parent's Name _____ Work Phone _____ Sport (s) _____

In case of emergency contact: Name _____ Phone _____ Cell _____

MEDICAL HISTORY

Yes/No

(to be completed by student & parents/guardians)

- Y N** 1. Have you had any illness/injury recently or now?
Y N 2. Have you had a medical problem, illness or injury since your last exam?
Y N 3. Do you have any chronic or recurrent illness?
Y N 4. Have you ever had an illness lasting more than a week?
Y N 5. Have you ever been hospitalized overnight?
Y N 6. Have you had any surgery?
Y N 7. Have you ever had any injuries requiring treatment by a physician?
Y N 8. Do you have any organs missing? (*appendix, eye, kidney, testicle, etc.*)
Y N 9. Are you presently taking **any** medications? (*including vitamins, aspirin*)
Y N 10. Do you have **any** allergies? (*medicine, bees, foods*)
Y N 11. Have you ever had chest pain, dizziness, fainting, or passing out during or after exercise?
Y N 12. Do you tire more easily or quickly than your friends during exercise?
Y N 13. Have you ever had any problem with your blood pressure or your heart?
Y N 14. Have any close relatives had heart problems, heart attacks, or sudden death **before** they were age 50?
Y N 15. Do you have any skin problems? (*acne, itching, rashes, etc.*)
Y N 16. Have you ever had fainting, convulsions, seizures or severe dizziness?
Y N 17. Do you have frequent severe headaches?
Y N 18. Have you ever had a "stinger" or "burner" or "pinched nerve?"
Y N 19. Have you ever been "knocked out" or "passed out?"
Y N 20. Have you ever had a neck or head injury?
Y N 21. Have you ever had heat exhaustion, heat stroke, heat cramps, or similar heat-related problems?
Y N 22. Do you have asthma, trouble breathing, or cough during or after exercise?
Y N 23. Do you wear eyeglasses, contact lenses, or protective eyewear?
Y N 24. Have you had any problem with your eyes or vision?
Y N 25. Do you wear any dental appliance? (*braces, bridge, plate, retainer*)
Y N 26. Have you ever had a knee or ankle injury?
Y N 27. Have you ever injured any other joint? (*shoulder, wrist, fingers, etc.*)
Y N 28. Have you ever had a broken bone? (*fracture*)
Y N 29. Have you ever had a cast, splint, or had to use crutches?
Y N 30. Must you use special equipment for competition? (*braces, etc.*)
Y N 31. Has it been more than eight years since your last tetanus booster shot?
Y N 32. Are you worried about your weight?
Y N 33. Have you any medical concerns about participating in your sport?
Y N 34. Are you taking any pills or drugs to increase your strength or performance?
Y N 35. **FEMALES:** Have you any menstrual problems?

I attest, by my signature below, that to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Parent/Guardian _____ Date _____

Signature of Student _____ Date _____

PHYSICAL

(to be completed by doctor)

Age _____ Height _____

Weight _____ BP _____

Pulse _____

Vision R ____ / ____ L ____ / ____

MEDICAL

Normal/Abnormal

Findings

N A Appearance _____

N A Eyes _____

N A Ears _____

N A Nose _____

N A Throat _____

N A Heart _____

N A Lymph Nodes _____

N A Pulses _____

N A Lungs _____

N A Abdomen _____

N A Genitalia (*males only*) _____

N A Skin _____

MUSCULOSKELETAL

N A Neck _____

N A Back _____

N A Shoulder/Arm _____

N A Elbow/Forearm _____

N A Wrist/Hand _____

N A Hip/Thigh _____

N A Knee _____

N A Leg/Ankle _____

N A Foot _____

ASSESSMENT

Full Participation Limited Participation

Describe limitations, restrictions _____

Participation contraindicated (*list reasons*) _____

Recommendations (*equipment, taping, rehabilitation, referral*) _____

Examiner's Name _____

Signature _____

Phone _____ Date _____