

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: _____ <input type="checkbox"/> Not examined
Pupils: _____	Skin: _____
Ears/Nose/Throat: _____	Other Remarks: _____
Dental/Braces: _____	_____
Lymph Nodes: _____	_____
Cardiac: Murmur: Yes _____ No _____	Strength: _____
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 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: _____ School: _____
 Student's Name: _____ Notify in emergency: _____
 Address: _____ Address: _____
 Phone: _____ Phone: _____
 Birth Date: _____ Age: _____ Grade: _____ Family Doctor: _____
 Date of last tetanus booster: _____ Phone: _____

<u>PLEASE CHECK ONE ANSWER</u>	<u>YES</u>	<u>NO</u>	<u>(Circle One) Left Handed Right Handed</u>	<u>YES</u>	<u>NO</u>
Has anyone <u>in your family</u> under age 50 died suddenly?	<input type="checkbox"/>	<input type="checkbox"/>	Have <u>you</u> had or do you now have other joint trouble?	<input type="checkbox"/>	<input type="checkbox"/>
Have <u>you</u> had or do you now have brain concussion (head injury)?	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
Tendency to lose consciousness (faint)?	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis?	<input type="checkbox"/>	<input type="checkbox"/>
Skull Fracture?	<input type="checkbox"/>	<input type="checkbox"/>	Have <u>you</u> had or do you now have diabetes (high sugar in blood or urine)?	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	Tendency to bleed or bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>
Neck injury?	<input type="checkbox"/>	<input type="checkbox"/>	Anemia ("tired blood")?	<input type="checkbox"/>	<input type="checkbox"/>
Headaches?	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had or do you now have very bad (impaired) vision in one eye?	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
Temporary loss of vision?	<input type="checkbox"/>	<input type="checkbox"/>	Have <u>you</u> had or do you now have Asthma (wheezing)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had or do you now have	<input type="checkbox"/>	<input type="checkbox"/>	Chest tightness & cough following running?	<input type="checkbox"/>	<input type="checkbox"/>
hearing loss?	<input type="checkbox"/>	<input type="checkbox"/>	Hives or rash?	<input type="checkbox"/>	<input type="checkbox"/>
Perforated ear drum?	<input type="checkbox"/>	<input type="checkbox"/>	Bee sting reactions (allergy)?	<input type="checkbox"/>	<input type="checkbox"/>
Discharge from ear (recurrent infections)?	<input type="checkbox"/>	<input type="checkbox"/>	Reaction to medicine (allergy)?	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infections?	<input type="checkbox"/>	<input type="checkbox"/>	Do <u>you</u> :		
Broken nose?	<input type="checkbox"/>	<input type="checkbox"/>	Use alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Dental Plate (dentures)?	<input type="checkbox"/>	<input type="checkbox"/>	Smoke or chew?	<input type="checkbox"/>	<input type="checkbox"/>
Removable retainer?	<input type="checkbox"/>	<input type="checkbox"/>	Take any medicine regularly?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had or do you now have	<input type="checkbox"/>	<input type="checkbox"/>	If yes, name _____		
a hernia?	<input type="checkbox"/>	<input type="checkbox"/>	Take medicine for emergency use?	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems (or absence of)?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, name _____		
Boys: Problem with testicles?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had or do you now have heart trouble or murmur?	<input type="checkbox"/>	<input type="checkbox"/>
Girls: Menstrual problems?	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Age of onset of menstruation _____			Persistent cough?	<input type="checkbox"/>	<input type="checkbox"/>
Breast lumps or tenderness?	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or faintness with heat?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had or do you now have broken bones/cast?	<input type="checkbox"/>	<input type="checkbox"/>	Cold sores?	<input type="checkbox"/>	<input type="checkbox"/>
Joint dislocation?	<input type="checkbox"/>	<input type="checkbox"/>	Fungus infection?	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder injury or recurrent pain?	<input type="checkbox"/>	<input type="checkbox"/>	Athlete's foot?	<input type="checkbox"/>	<input type="checkbox"/>
Elbow injury or recurrent pain?	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent boils (skin infection)?	<input type="checkbox"/>	<input type="checkbox"/>
Back injury or frequent backaches?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any other injuries or illness that caused you to miss a game or practice?	<input type="checkbox"/>	<input type="checkbox"/>
Knee injury, recurrent pain or swelling?	<input type="checkbox"/>	<input type="checkbox"/>			
Shin splints or recurring leg pain?	<input type="checkbox"/>	<input type="checkbox"/>			
Ankle injury or recurrent pain?	<input type="checkbox"/>	<input type="checkbox"/>			
Foot problems?	<input type="checkbox"/>	<input type="checkbox"/>			

ADDITIONAL HISTORY INFORMATION _____

PHYSICIAN'S REMARKS _____

I HAVE READ THIS FORM. ALL INFORMATION IS ACCURATE.

Parent Signature Required

Physician's Signature _____

Use back of form to provide further information