

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 (<i>males only</i>) _____
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 _____