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

(to be completed by student & parents/guardians)

Yes/No	
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?

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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)* ________

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Examiner's Name ________

Signature ________

Phone ________ Date ________

Form # 254-93