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 PARTICIPATING: Fall: _____ Winter: _____ Spring :_____

Height: _____ Weight: _____ % Body Fat (opt.): _____ Pulse: _____ BP: _____

Vision: R 20/ ____ L 20/ ____ Corrected: ☐ Yes ☐ No Pupils: Equal _____

Unequal_____

MEDICAL	**NORMAL***	**ABNORMAL FINDINGS**
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitilia (males only)		
Skin		

MUSCULOSKELETAL	**NORMAL ***	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

***Normal by (✔) or No**

☐ Cleared

☐*Cleared after completing evaluation/rehabilitation for: _____

_____

☐Not cleared for: : _____

Reason:_____

Recommendations: _____

_____

Physician's Name (print/type):_____ Date:_____

Address:_____ Phone:_____

Signature of Physician: _____ ☐MD ☐DO

MEDICAL/HEALTH HISTORY

Please explain "Yes" answers on the bottom of the page

Y	N	
□	□	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 than 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	
□	□	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?_____
Y	**N**	
□	□	15. Has a physician ever denied or restricted your participation in sports or any physical activity?

Explain all "Yes" answers

_____
_____
_____
_____
_____
_____
_____
_____
_____