**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 check (√) 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 bottom of 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 that 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**

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**Please Turn In Together: 1) Completed Physical 2) Insurance Application 3) Insurance Premium Payment**

**to the School Athletic Director or Athletic/Activities Facilitator-ML At The Same Time**

Revised 11/18/2020