**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:** | | |  | | | | | | | | | | | | | | |
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|  | | | | | | |  | | |  | | | | | | | |
| **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