

PORT TOWNSEND SCHOOL DISTRICT NO.50 SPORTS PRE-PARTICIPATION EXAM REPORT

History

Name _____ Grade _____ Sex _____ Date of Birth _____

Address _____ Telephone _____ Family Physician _____

In case of emergency, notify:

Name _____ Address _____ Telephone _____

Date of last tetanus booster _____ Date of last examination by a doctor _____

The following questions are to be answered by either yes or no. Please check the appropriate space.

	Yes	No		Yes	No
Have you been under a doctor's care in the past 12 months?	()	()	Have you had or do you now have:		
Have you been in the hospital in the past 12 months?	()	()	Back injury or frequent backaches?	()	()
Have you ever had any type of surgery?	()	()	Knee injury (sprain) or recurrent pain?	()	()
Do you want to talk to a doctor about a health problem or an injury?	()	()	Ankle injury (sprain) or recurrent pain?	()	()
Has anyone in your immediate family ever had:			Other joint problems (e.g., swelling, pain, decreased range of motion)?	()	()
Diabetes (high sugar in blood)?	()	()	Bone infection?	()	()
Allergies (hay fever or asthma)?	()	()	Have you had or do you now have:		
Migraine headaches?	()	()	Diabetes (high sugar in blood or urine)?	()	()
Heart trouble?	()	()	Tendency to bleed or bruise easily?	()	()
High blood pressure?	()	()	Anemia ("tired" blood)?	()	()
Has anyone in your family, under age 50, died suddenly?	()	()	Weight problem (under or overweight)?	()	()
Have you had or do you now have:			Have you had or do you now have:		
Brain concussion (head injury)?	()	()	Asthma (wheezing)?	()	()
Tendency to lose consciousness (faint)?	()	()	Hay fever?	()	()
Skull fracture?	()	()	Hives or rash?	()	()
Convulsions or epilepsy?	()	()	Bee-sting reactions (allergy)?	()	()
Neck injury?	()	()	Reaction to medicine (allergy)?	()	()
Have you had or do you now have:			Do you:		
Very bad (impaired) vision in one eye?	()	()	Smoke?	()	()
Temporary loss of vision?	()	()	Take any medicine regularly?	()	()
To wear glasses or contact lenses?	()	()	If YES, name of medication _____		
Have you had or do you now have:			Take medicine for emergency use?	()	()
Hearing loss?	()	()	If YES, name of medication _____		
Perforated eardrum?	()	()	Have you had or do you now have:		
Discharge from ear(s) (recurrent infections)?	()	()	Heart trouble or murmur?	()	()
Sinus infections?	()	()	High blood pressure?	()	()
Broken nose?	()	()	Persistent cough?	()	()
Dental plate (dentures)?	()	()	Chest pain with exercise?	()	()
Orthodontia (teeth straightened)?	()	()	Dizziness or faintness with exercise?	()	()
Have you had or do you now have:			Have you had or do you now have:		
Hernia?	()	()	Recurrent rash?	()	()
Kidney problems?	()	()	Fungus infection?	()	()
Loss of function/absence of testicles (boys)?	()	()	Athlete's foot?	()	()
Menstrual problems (girls)?	()	()	Recurrent boils (skin infection)?	()	()
Age at onset of menstruation _____			Do you wish to discuss an emotional problem with the doctor?	()	()
Have you had or do you now have:			Have you ever been told to give up sports because of a health problem?	()	()
Bone fracture?	()	()	If you have answered yes to any of the above questions, please explain below:		
Joint dislocation?	()	()	_____		
Foot problems?	()	()	_____		
To wear a cast?	()	()			

I certify that the above information is correct, and give permission for my child to participate in interscholastic sports.

Parent/Guardian Signature _____ Date _____

Please be advised that the pre-participation screening physical examination in no way constitutes a complete physical examination.

PHYSICAL EXAMINATION

1. Height _____ Weight _____

2. Blood Pressure (sitting) _____

3. Vision: Left 20/ _____ Right 20/ _____

Check if
within normal
limits

- 4. Skin ()
- 5. Mouth ()
- 6. Eyes ()
- 7. Ears ()
- 8. Neck ()
- 9. Lymphatics ()
- 10. Respiratory ()
- 11. Cardiovascular ()
 - Heart ()
 - Pulses ()
- 12. Abdomen ()
- 13. Genitalia ()
- 14. Extremities ()
- 15. Neurologic ()
 - Reflexes ()
- 16. Orthopedic ()
 - Cervical spine/back ()
 - Arm/elbow/wrist/hand ()
 - Knees ()
 - Ankles ()

PHYSICIAN'S STATEMENT OF HEALTH

Those licensed to perform physical examinations include a Medical Doctor (MD), Doctor of Osteopathy (DO), Advanced Registered Nurse Practitioner (ARNP), Physician's Assistant (PA), and Naturopathic Physician.

I certify that I have examined _____ and have found no gross evidence of any abnormality that will interfere with his or her participation.

_____, MD, DO, ARNP, or PA
Date Signature

Name of Physician (Please Print)

Name of Clinic

Telephone Number