

Central Kitsap School District  
**INITIAL PHYSICAL EXAMINATION FOR ATHLETIC COMPETITION**  
 TO BE COMPLETED BEFORE ENTRY INTO ATHLETICS

Name: \_\_\_\_\_ Visual Acuity: L 20/ \_\_\_\_\_ R 20/ \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ With/Without Correction  
 Contact Lenses (circle one) Y N  
 Blood Pressure (Sitting, Rt. Arm): \_\_\_\_\_  
 Pulse: Resting pulse \_\_\_\_\_  
 Lab\*: Hct \_\_\_\_\_ Sickle Cell \_\_\_\_\_  
 Urinalysis\*: Protein \_\_\_\_\_ Sugar \_\_\_\_\_ Blood \_\_\_\_\_  
 \*Optional (Urinalysis needs parent authorization.)

General Appearance/Somatotype: \_\_\_\_\_ Abdomen: \_\_\_\_\_  
 Eyes: E.O.M. \_\_\_\_\_ Genitalia: \_\_\_\_\_  Not examined  
 Pupils: \_\_\_\_\_ Skin: \_\_\_\_\_  
 Ears/Nose/Throat: \_\_\_\_\_ Other Remarks: \_\_\_\_\_  
 Dental/Braces: \_\_\_\_\_  
 Lymph Nodes: \_\_\_\_\_  
 Cardiac: Murmur: Yes \_\_\_\_\_ No \_\_\_\_\_  
 Pulse: Regular \_\_\_\_\_ Irregular \_\_\_\_\_  
 Respiratory: \_\_\_\_\_ Strength: \_\_\_\_\_  
 Posture/Neck/Back/Scoliosis: \_\_\_\_\_ Flexibility: \_\_\_\_\_  
 \_\_\_\_\_  
 Upper Extremities: \_\_\_\_\_ General Conditioning: \_\_\_\_\_  
 \_\_\_\_\_  
 Lower Extremities: \_\_\_\_\_  
 \_\_\_\_\_

**DISPOSITION AND RECOMMENDATIONS** (USE BACK OF FORM FOR ADDITIONAL INFORMATION)

DIAGNOSIS OR PROBLEM	TREATMENT RECOMMENDATIONS
1) _____	_____
2) _____	_____
3) _____	_____

- DISPOSITION:** \_\_\_\_\_
- 1) Unrestricted activity in high school sports grades 9-12
  - 2) Unrestricted activity in any sport grades 7-8
  - 3) Unrestricted activity in all sports except \_\_\_\_\_
  - 4) No participation until \_\_\_\_\_
  - 5) Conditional participation, limited to \_\_\_\_\_
  - 6) No participation in any sport

\_\_\_\_\_ Date \_\_\_\_\_ Doctor's Signature \_\_\_\_\_ Phone \_\_\_\_\_

# HEALTH HISTORY FORM FOR ATHLETIC COMPETITION

TO BE COMPLETED BEFORE VISIT TO HEALTH PROFESSIONAL

Date: \_\_\_\_\_ School: \_\_\_\_\_  
 Student's Name: \_\_\_\_\_ Notify in emergency: \_\_\_\_\_  
 Address: \_\_\_\_\_ Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Family Doctor: \_\_\_\_\_  
 Date of last tetanus booster: \_\_\_\_\_ Phone: \_\_\_\_\_

<u>PLEASE CHECK ONE ANSWER</u>	<u>YES</u>	<u>NO</u>	<u>(Circle One) Left Handed Right Handed</u>	<u>YES</u>	<u>NO</u>
Has anyone <b>in your family</b> under age 50 died suddenly? .....	<input type="checkbox"/>	<input type="checkbox"/>	Have <b>you</b> had or do you now have other joint trouble? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have <b>you</b> had or do you now have brain concussion (head injury)? .....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis? .....	<input type="checkbox"/>	<input type="checkbox"/>
Tendency to lose consciousness (faint)? .....	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis? .....	<input type="checkbox"/>	<input type="checkbox"/>
Skull Fracture? .....	<input type="checkbox"/>	<input type="checkbox"/>	Have <b>you</b> had or do you now have diabetes (high sugar in blood or urine)? .....	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions or epilepsy? .....	<input type="checkbox"/>	<input type="checkbox"/>	Tendency to bleed or bruise easily? .....	<input type="checkbox"/>	<input type="checkbox"/>
Neck injury? .....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia ("tired blood")? .....	<input type="checkbox"/>	<input type="checkbox"/>
Headaches? .....	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had or do you now have very bad (impaired) vision in one eye? .....	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease? .....	<input type="checkbox"/>	<input type="checkbox"/>
Temporary loss of vision? .....	<input type="checkbox"/>	<input type="checkbox"/>	Have <b>you</b> had or do you now have Asthma (wheezing)? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear glasses or contact lenses? .....	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had or do you now have .....	<input type="checkbox"/>	<input type="checkbox"/>	Chest tightness & cough following running? .....	<input type="checkbox"/>	<input type="checkbox"/>
hearing loss? .....	<input type="checkbox"/>	<input type="checkbox"/>	Hives or rash? .....	<input type="checkbox"/>	<input type="checkbox"/>
Perforated ear drum? .....	<input type="checkbox"/>	<input type="checkbox"/>	Bee sting reactions (allergy)? .....	<input type="checkbox"/>	<input type="checkbox"/>
Discharge from ear (recurrent infections)? .....	<input type="checkbox"/>	<input type="checkbox"/>	Reaction to medicine (allergy)? .....	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infections? .....	<input type="checkbox"/>	<input type="checkbox"/>	Do <b>you</b> :		
Broken nose? .....	<input type="checkbox"/>	<input type="checkbox"/>	Use alcohol or drugs? .....	<input type="checkbox"/>	<input type="checkbox"/>
Dental Plate (dentures)? .....	<input type="checkbox"/>	<input type="checkbox"/>	Smoke or chew? .....	<input type="checkbox"/>	<input type="checkbox"/>
Removable retainer? .....	<input type="checkbox"/>	<input type="checkbox"/>	Take any medicine regularly? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had or do you now have .....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, name _____		
a hernia? .....	<input type="checkbox"/>	<input type="checkbox"/>	Take medicine for emergency use? .....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems (or absence of)? .....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, name _____		
Boys: Problem with testicles? .....	<input type="checkbox"/>	<input type="checkbox"/>	Have you had or do you now have heart trouble or murmur? .....	<input type="checkbox"/>	<input type="checkbox"/>
Girls: Menstrual problems? .....	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure? .....	<input type="checkbox"/>	<input type="checkbox"/>
Age of onset of menstruation _____			Persistent cough? .....	<input type="checkbox"/>	<input type="checkbox"/>
Breast lumps or tenderness? .....	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or faintness with heat? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had or do you now have broken bones/cast? .....	<input type="checkbox"/>	<input type="checkbox"/>	Cold sores? .....	<input type="checkbox"/>	<input type="checkbox"/>
Joint dislocation? .....	<input type="checkbox"/>	<input type="checkbox"/>	Fungus infection? .....	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder injury or recurrent pain? .....	<input type="checkbox"/>	<input type="checkbox"/>	Athlete's foot? .....	<input type="checkbox"/>	<input type="checkbox"/>
Elbow injury or recurrent pain? .....	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent boils (skin infection)? .....	<input type="checkbox"/>	<input type="checkbox"/>
Back injury or frequent backaches? .....	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any other injuries or illness that caused you to miss a game or practice? .....	<input type="checkbox"/>	<input type="checkbox"/>
Knee injury, recurrent pain or swelling? .....	<input type="checkbox"/>	<input type="checkbox"/>			
Shin splints or recurring leg pain? .....	<input type="checkbox"/>	<input type="checkbox"/>			
Ankle injury or recurrent pain? .....	<input type="checkbox"/>	<input type="checkbox"/>			
Foot problems? .....	<input type="checkbox"/>	<input type="checkbox"/>			

**ADDITIONAL HISTORY INFORMATION** \_\_\_\_\_

PHYSICIAN'S REMARKS \_\_\_\_\_

I HAVE READ THIS FORM. ALL INFORMATION IS ACCURATE.

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Parent Signature Required

Physician's Signature \_\_\_\_\_

Use back of form to provide further information