PRE-PARTICIPATION SPORTS PHYSICAL EVALUATION

WIAA 18.13.4 The physical examination dated June 1, 2004 or later shall be valid for twenty-four (24) consecutive months to the date unless otherwise limited by local school district policy. All physical examinations conducted prior to June 1, 2004 would be valid for thirteen (13) months.

Section A: To be completed by Parent

Name ______________________________ ☐ Male ☐ Female

Address ______________________________ City ______________ Zip __________

Phone ______________ Date of Birth ______________ Your age today __________

Grade in the Fall ______________ School in the Fall ______________________

Activity Fall ______________ Winter ______________ Spring ______________

ATHLETICS INSURANCE INFORMATION

While I expect school authorities to exert reasonable precaution to avoid injury, I understand that they assume no financial or moral obligation for accidents. I understand that my student cannot participate in boys/girls athletics unless he/she is covered by insurance with the minimum provisions. I accept full responsibility for the cost of treatment for any injury which he/she may suffer while participating in the program.

INSURANCE WAIVER

I have insurance coverage with ______________________ Company that provides adequate accident coverage and will keep it in force throughout the sports year.

SCHOOL INSURANCE

I do not have a family insurance policy. However, I purchased school insurance for the above named student on ______________ and paid a premium of $__________.

Do you have a personal physician? ☐ No ☐ Yes Physician's Name ______________________

Explain "Yes" answers below:

	Yes	No
1. Have you ever been hospitalized?	☐	☐
2. Have you ever had surgery?	☐	☐
3. Are you presently taking any medications or pills?	☐	☐
4. Do you have any allergies (medicine, bees or other stinging insects)?	☐	☐
5. Have you ever passed out during or after exercise?	☐	☐
6. Have you ever been dizzy during or after exercise?	☐	☐
7. Have you ever had chest pain during or after exercise?	☐	☐
8. Do you tire more quickly than your friends during exercise?	☐	☐
9. Have you ever had high blood pressure?	☐	☐
10. Have you ever been told that you have a heart murmur?	☐	☐
11. Have you ever had racing of your heart or skipped heartbeats?	☐	☐
12. Has anyone in your family died of heart problems or a sudden death before age 50?	☐	☐
13. Do you have any skin problems (itching, rashes, acne)?	☐	☐
14. Have you ever had a head injury?	☐	☐
15. Have you ever been knocked out or unconscious?	☐	☐
16. Have you ever had a seizure?	☐	☐
17. Have you ever had a stinger, burner or pinched nerve?	☐	☐
18. Have you ever had heat or muscle cramps?	☐	☐
19. Have you ever been dizzy or passed out in the heat?	☐	☐
20. Do you have trouble breathing or do you cough during or after activity?	☐	☐
21. Do you use any special equipment (pads, braces neck rolls, mouth guard, eye guards, etc.)	☐	☐
22. Have you had any problems with your eyes or vision?	☐	☐
23. Do you wear glasses or contacts or protective eye wear?	☐	☐

24. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?............ ☐ ☐

☐ Head ☐ Shoulder ☐ Thigh ☐ Neck ☐ Elbow ☐ Knee ☐ Chest ☐ Foot

☐ Forearm ☐ Shin/calf ☐ Back ☐ Wrist ☐ Ankle ☐ Hip ☐ Hand

25. Have you had any other medical problems (infections mononucleosis, diabetes, etc.)?............ ☐ ☐

26. Have you had a medical problem or injury since your last evaluation?............ ☐ ☐

27. When was your last tetanus shot?............

28. When was your last measles immunization?............

29. When was your first menstrual period?............

30. When was your last menstrual period?............

31. What was the longest time between your periods last year?............

Explain "Yes" answers: ______________________________

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I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Student Signature ______________________________ **Date** ______________

Parent/Guardian Signature ______________________________ **Date** ______________

Section B: To be completed by Physician

PHYSICAL EXAMINATION

		Height Weight	BP /	Pulse	
			Normal	Abnormal Findings	Initials
Complete	Limited	Cardiopulmonary			
		Pulses			
		Heart			
		Lungs			
		Skin			
		Abdominal			
		Musculoskeletal			
		Neck/Spine			
		Upper Extremities			
		Lower Extremities			

CLEARANCE

A. ☐ **Cleared**

B. ☐ **Not cleared for:** ☐ **Collision** ☐ **Contact** ☐ **Non-contact** ☐ **Strenuous** ☐ **Moderately strenuous** ☐ **Non-strenuous**

Due to ______________________________

Recommendation: ______________________________

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Name of Physician ______________________________ **Date** ______________

Signature of Physician ______________________________