KAMEHAMEHA SCHOOLS PHYSICAL EVALUATION FORM

Instructions: Complete the top two lines and have your healthcare provider complete the rest.
Please ensure all fields are completed before returning this form.

Student Name: _____ **DOB**: _____ **Grade Entering**: _____ **ID #**: _____

Residency: ■ Hawai'i State ☐ Out-of-state **Student Status**: ☐ Returning ☐ New / ☐ Day ☐ Boarding

PROVIDER TO COMPLETE (Blank fields will be considered as None or Normal)	
Medical and Mental Health Conditions: h/o COVID-19: ☐ Yes ☐ No	**Allergies/Reactions**:
Current Medications & Dosage: Epi-Pen: ☐ Yes ☐ No Albuterol Inhaler: ☐ Yes ☐ No	**Additional Comments:**

Please send most current immunization record with PE form.

Height:	Weight:	BMI:	Vision: R 20 / L 20 / Corrected ☐ Yes ☐ No
BP:	Pulse:	**Normal**	**Abnormal Finding**
Appearance • Marfan stigmata			
Eyes/ears/nose/throat • Pupils equal • Hearing			
Lymph nodes			
Heart • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin • HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic			
Musculoskeletal • Neck/back • UE/shoulder/elbow/wrist/hand • LE/hip/knee/ankle/foot • Functional/duck walk/single leg hop			
Mental Health • Depression • Tobacco/ Vaping Use			

MEDICAL CLEARANCE

	Medically Cleared (check all that apply) Yes	No	Restrictions or other Comments
School			
Physical Education			
Sports			

I have reviewed the Health History and completed the physical examination documented on this form for the above-named student. Based on my clinical assessment, the student is cleared to attend school and participate in physical education and sports as indicated above. I attest that I am a licensed physician (MD, DO), Nurse Practitioner (NP or APRN), or Physician Assistant (PA).

Name of Provider Frank R. Baum, M.D. **Examination Date** _____

Address 200 Kalepa Place, Kahului HI. 96732 Phone 808-871-7116

Signature of Provider _____ Today's Date _____

Instructions: Complete this page and give it to your healthcare provider to review. Do not return this page to KS.

Student Name_____ Date of Birth_____

General Questions	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify: ☐Asthma ☐Anemia ☐Diabetes ☐Infections Other:		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
Heart Health Questions About You	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐High Blood Pressure ☐ A heart murmur ☐High cholesterol ☐ A heart infection ☐Kawasaki disease ☐ Other:		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
Heart Health Questions About Your Family	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
Bone and Joint Questions	**Yes**	**No**
17. Have you ever had any stress fracture, broken or fractured bones, or dislocated joints?		
18. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
19. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)?		
20. Do you regularly use a brace, orthotics, or other assistive device?		
21. Have you ever had or do you currently have a bone, muscle, or joint injury that bothers you?		
22. Do any of your joints become painful, swollen, feel warm, or look red?		
23. Do you have any history of juvenile arthritis or connective tissue disease?		

Medical Questions	Yes	No
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
25. In the past year, have you used an inhaler or taken asthma medicine?		
26. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
27. Do you have groin pain or a painful bulge or hernia in the groin area?		
28. Have you had infectious mononucleosis (mono) within the last month?		
29. Have you had a herpes or MRSA skin infection?		
30. Have you ever had a head injury or concussion? If so, date of last occurrence:		
31. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
32. Do you have a history of seizure disorder?		
33. Do you have headaches with exercise?		
34. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
35. Have you ever been unable to move your arms or legs after being hit or falling?		
36. Have you ever become ill while exercising in the heat?		
37. Do you get frequent muscle cramps when exercising?		
38. Do you or someone in your family have sickle cell trait or disease?		
39. Have you had any problems with your eyes or vision?		
40. Have you had any eye injuries?		
41. Do you wear protective eyewear, such as goggles or a face shield?		
42. Do you worry about your weight?		
43. Are you trying to or has anyone recommended that you gain or lose weight?		
44. Are you on a special diet or do you avoid certain types of foods?		
45. Have you ever had an eating disorder?		
46. Do you have any concerns that you would like to discuss with a doctor?		
47. Do you take any nutritional or dietary supplements?		
48. Have you ever tested positive for COVID-19?		
Females Only	**Yes**	**No**
49. Have you ever had a menstrual period?		
50. How many periods have you had in the last 12 months?		

For "Yes" responses, provide details below (use additional sheets if needed):

_____

Signature of Parent/Guardian Date