WHATCOM COUNTY SPORTS PHYSICAL EXAM

(Required prior to participation in Middle & High Schools – PARENTS MUST REVIEW & SIGN)

☐ Pre-Participation
☐ Returning

Name _____ **Birth Date** _____ **School** _____ **Exam Date** _____

Address _____ **City** _____ **Phone** _____

Parent's Name _____ **Work Phone** _____ **Sport (s)** _____

In case of emergency contact: Name _____ **Phone** _____ **Cell** _____

MEDICAL HISTORY

Yes/No *(to be completed by student & parents/guardians)*

Y N 1. Have you had any illness/injury recently or now?
Y N 2. Have you had a medical problem, illness or injury since your last exam?
Y N 3. Do you have any chronic or recurrent illness?
Y N 4. Have you ever had an illness lasting more than a week?
Y N 5. Have you ever been hospitalized overnight?
Y N 6. Have you had any surgery?
Y N 7. Have you ever had any injuries requiring treatment by a physician?
Y N 8. Do you have any organs missing? *(appendix, eye, kidney, testicle, etc.)*
Y N 9. Are you presently taking **any** medications? *(including vitamins, aspirin)*
Y N 10. Do you have **any** allergies? *(medicine, bees, foods)*
Y N 11. Have you ever had chest pain, dizziness, fainting, or passing out during or after exercise?
Y N 12. Do you tire more easily or quickly than your friends during exercise?
Y N 13. Have you ever had any problem with your blood pressure or your heart?
Y N 14. Have any close relatives had heart problems, heart attacks, or sudden death **before** they were age 50?
Y N 15. Do you have any skin problems? *(acne, itching, rashes, etc.)*
Y N 16. Have you ever had fainting, convulsions, seizures or severe dizziness?
Y N 17. Do you have frequent severe headaches?
Y N 18. Have you ever had a "stinger" or "burner" or "pinched nerve?"
Y N 19. Have you ever been "knocked out" or "passed out?"
Y N 20. Have you ever had a neck or head injury?
Y N 21. Have you ever had heat exhaustion, heat stroke, heat cramps, or similar heat-related problems?
Y N 22. Do you have asthma, trouble breathing, or cough during or after exercise?
Y N 23. Do you wear eyeglasses, contact lenses, or protective eyewear?
Y N 24. Have you had any problem with your eyes or vision?
Y N 25. Do you wear any dental appliance? *(braces, bridge, plate, retainer)*
Y N 26. Have you ever had a knee or ankle injury?
Y N 27. Have you ever injured any other joint? *(shoulder, wrist, fingers, etc.)*
Y N 28. Have you ever had a broken bone? *(fracture)*
Y N 29. Have you ever had a cast, splint, or had to use crutches?
Y N 30. Must you use special equipment for competition? *(braces, etc.)*
Y N 31. Has it been more than eight years since your last tetanus booster shot?
Y N 32. Are you worried about your weight?
Y N 33. Have you any medical concerns about participating in your sport?
Y N 34. Are you taking any pills or drugs to increase your strength or performance?
Y N 35. **FEMALES:** Have you any menstrual problems?

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I attest, by my signature below, that to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Parent/Guardian _____ **Date** _____

Signature of Student _____ **Date** _____

PHYSICAL

(to be completed by doctor)

Age _____ **Height** _____
Weight _____ **BP** _____
Pulse _____
Vision R ____/____ **L** ____/____

MEDICAL

Normal/Abnormal *Findings*

N A Appearance _____
N A Eyes _____
N A Ears _____
N A Nose _____
N A Throat _____
N A Heart _____
N A Lymph Nodes _____
N A Pulses _____
N A Lungs _____
N A Abdomen _____
N A Genitalia *(males only)* _____
N A Skin _____

MUSCULOSKELETAL

N A Neck _____
N A Back _____
N A Shoulder/Arm _____
N A Elbow/Forearm _____
N A Wrist/Hand _____
N A Hip/Thigh _____
N A Knee _____
N A Leg/Ankle _____
N A Foot _____

ASSESSMENT

☐ **Full Participation** ☐ **Limited Participation**

Describe limitations, restrictions _____

Participation contraindicated *(list reasons)* _____

Recommendations *(equipment, taping, rehabilitation, referral)* _____

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Examiner's Name _____
Signature _____
Phone _____ **Date** _____

Form # 254-03