

KENT SCHOOL DISTRICT ATHLETIC DEPARTMENT PREPARTICIPATION HISTORY AND PHYSICAL EXAMINATION

Name: _____ Birth Date: _____ Exam Date: _____ Grade: (2010-2011)

Address: _____ City: _____ Zip: _____

Phone: _____ Sport: _____

EXAMINER'S NOTE: This examination is for participation at the middle school level (grades 7-8).

This examination is for participation at the senior high level (grades 9-12).

Athlete and Parent/Guardian: Please review all questions and answer them to the best of your ability.

Physician: Please review with the athlete details of any positive answers.

HISTORY

- | | Yes | No | |
|-------|--------------------------|--------------------------|----------------------------------------------------------------------------------------------------|
| 1 a. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any illness/injury recently, or do you have an illness/injury now? |
| b. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had a medical problem, illness or injury since your last exam? |
| c. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any chronic or recurrent illness? |
| d. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any illness lasting more than a week? |
| e. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hospitalized overnight? |
| f. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any surgery other than tonsillectomy? |
| g. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any injuries requiring treatment by a physician? |
| h. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc.)? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Are you presently taking ANY medications (including birth control pill, vitamin, aspirin, etc.)? |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have ANY allergies (medicines, bees, foods, or other factors)? |
| 4 a. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had chest pain, dizziness, fainting, passing out during or after exercise? |
| b. | <input type="checkbox"/> | <input type="checkbox"/> | Do you tire more easily or quickly than your friends during exercise? |
| c. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any problem with your blood pressure or your heart? |
| d. | <input type="checkbox"/> | <input type="checkbox"/> | Have any close relatives had heart problems, heart attack or sudden death before they were age 50? |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any skin problems (acne, itching, rashes, etc.)? |
| 6 a. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had fainting, convulsions, seizures or severe dizziness? |
| b. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have frequent severe headaches? |
| c. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a "stinger" or "burner" or "pinched nerve"? |
| d. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been "knocked out" or "passed out"? |
| e. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a neck injury, head injury or concussion? |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems? |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had asthma, or trouble breathing, or cough during or after exercise? |
| 9 a. | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear eyeglasses, contact lenses or protective eye wear? |
| b. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any problem with your eyes or vision? |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear any dental appliance such as braces, bridge, plate, retainer? |
| 11 a. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a knee injury? |
| b. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an ankle injury? |
| c. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever injured any other joint (shoulder, wrist, fingers, etc.)? |
| d. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a broken bone (fracture)? |
| e. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a cast, splint, or had to use crutches? |
| f. | <input type="checkbox"/> | <input type="checkbox"/> | Must you use special equipment for competition (pads, braces, neck roll, etc.)? |
| 12. | <input type="checkbox"/> | <input type="checkbox"/> | Has it been more than 5 years since your last tetanus booster shot? |
| 13. | <input type="checkbox"/> | <input type="checkbox"/> | Are you worried about your weight? |
| 14. | <input type="checkbox"/> | <input type="checkbox"/> | FEMALES: Have you any menstrual problems? |
| 15. | <input type="checkbox"/> | <input type="checkbox"/> | Have you any medical concerns about participating in your sport? |

***** ATHLETE SHOULD NOT WRITE BELOW THIS LINE *****

EXAMINER'S COMMENTS ON ALL "YES" ANSWERS (refer to question number):

KENT SCHOOL DISTRICT ATHLETIC DEPARTMENT

STUDENT NAME: _____

EXPIRATION DATE: _____
(SCHOOL USE ONLY)

PHYSICAL EXAMINATION

Age: _____ Weight: _____ Pulse: _____ Blood Pressure: _____

Height: _____ Visual Acuity: Left 20/_____
Right 20/_____

Normal

Abnormal

- | | | | | |
|--------------------------|-----|------------------------------|--------------------------|-------|
| <input type="checkbox"/> | 1. | Head | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 2. | Eyes (pupils), ENT | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 3. | Teeth | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 4. | Chest | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 5. | Lungs | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 6. | Heart | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 7. | Abdomen | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 8. | Genitalia | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 9. | Neurologic | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 10. | Skin | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 11. | Physical Maturity | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 12. | Spine, Back | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 13. | Shoulders, Upper extremities | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 14. | Lower extremities | <input type="checkbox"/> | _____ |

PLEASE NOTE: THIS EXAMINATION IS FOR A PERIOD OF 24 MONTHS PER WIAA REGULATION, UNLESS OTHERWISE INDICATED.

- Assessment: Full participation at the senior high level (grades 9-12).
 Full participation at the middle school level (grades 7-8).
 Limited participation (describe limitations, restrictions):
- } To be eligible to participate, an examiner must check one of these boxes.

 Participation contraindicated (list reasons):

Recommendations (equipment, taping, rehabilitation, etc.):

EXAMINER'S SIGNATURE: _____ DATE: _____

PRINT EXAMINER'S NAME: _____ EXAMINER'S PHONE NUMBER: (____) _____