Physical Examination

(to be completed by examiner)

Age: _____ Pulse: _____

Height: _____ Blood Pressure: _____

Weight: _____ Visual Acuity: Left 20/_____

Right 20/ _____

Normal	Abnormal
❑ 1. Head	❑ _____
❑ 2. Eyes (pupils), ENT	❑ _____
❑ 3. Teeth	❑ _____
❑ 4. Lungs	❑ _____
❑ 5. Heart	❑ _____
❑ 6. Abdomen	❑ _____
❑ 7. Neurologic	❑ _____
❑ 8. Skin	❑ _____
❑ 9. Spine, Back	❑ _____
❑ 10. Shoulders, Upper Extremities	❑ _____
❑ 11. Lower Extremities	❑ _____

Assessment: ❑ Full Participation

❑ Limited Participation (describe limitations, restrictions)

_____

❑ Participation Contraindicated (list reasons):

_____

Recommendations (see your healthcare provider):

_____

Follow-up With: _____

_____ _____

Examiner's Phone Examiner's Printed Name

_____ _____

Date Examiner's Signature

Revised 5.3.13

Olympia School District

Physical Examination Form

Name: _____

Address: _____

_____

Email: _____

Home Phone: _____

Cell Phone: _____

Sport(s): _____

Primary Care Provider Name: _____

_____

Health Insurance (State "none" if applicable):

_____

Examination Date: _____

Pre-participation History and Physical Examination (to be completed by student / parent /legal guardian prior to examination)				Examiner's Comments on all "YES" Answers (refer to question number):
	YES	NO		
1.	❑	❑	Have you had any illness/injury within the past year which required you to see a healthcare provider?	
2.	❑	❑	Do you have any chronic or recurrent illness?	
3.	❑	❑	Have you ever been hospitalized overnight?	
4.	❑	❑	Have you ever had any surgery?	
5.	❑	❑	Have you ever had any injuries requiring treatment by a physician?	
6.	❑	❑	Do you have any organs missing (spleen, eye, kidney, testicle, lung)?	
7.	❑	❑	Are you presently taking ANY medications (including birth control pill, vitamin, aspirin, etc.)?	
8.	❑	❑	Do you have ANY allergies (medicines, bees, foods, or other factors)?	
9.	❑	❑	Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?	
10.	❑	❑	Do you tire more easily or quickly than your friends during exercise?	
11.	❑	❑	Have you ever had any problem with your blood pressure or your heart?	
12.	❑	❑	Have any close relatives had heart problems, heart attack or sudden death **before** they were age 50?	
13.	❑	❑	Do you have any skin problems (new or changing moles, lumps)?	
14.	❑	❑	Have you had fainting, convulsions, seizures or severe dizziness?	
15.	❑	❑	Do you have frequent severe headaches?	
16.	❑	❑	Have you ever had a "stinger" or "burner" or "pinched nerve"?	
17.	❑	❑	Have you ever been "knocked out", had a concussion, or other head injury?	
18.	❑	❑	Have you ever had a neck or head injury?	
19.	❑	❑	Have you ever had heat exhaustion or heat stroke?	
20.	❑	❑	Have you had asthma, or trouble breathing, or cough during or after exercise?	
21.	❑	❑	Do you wear eyeglasses, contact lenses or protective eye wear during exercise?	
22.	❑	❑	Have you had any problem with your eyes or vision?	
23.	❑	❑	Do you wear any dental appliance such as braces, bridge, plate, retainer?	
24.	❑	❑	Have you ever had a knee injury?	
25.	❑	❑	Have you ever had an ankle injury?	
26.	❑	❑	Have you ever injured any other joint (shoulder, wrist, fingers, etc.) or have loose joints?	
27.	❑	❑	Have you ever had a broken bone (fracture)?	
28.	❑	❑	Must you use special equipment for competition (pads, braces, neck roll, etc.)?	
29.	❑	❑	When was your last tetanus booster shot?	
30.	❑	❑	FEMALES: Do you have any menstrual problems? Anemia?	
31.	❑	❑	Do you have any medical concerns about participating in your sport?	