

Current Sport _____

SHORELINE SCHOOL DISTRICT

Sport Physical is good from 24 months based on the **date of the actual physical exam** by the Health care practitioner.

1/14

All sections outlined in bold boxes are to be completed by health care provider

SECONDARY STUDENT HEALTH REPORT

HEALTH HISTORY Completed by Parent/Guardian

NAME _____ BIRTHDATE _____ GRADE _____

ADDRESS _____ PHONE _____

PARENT/GUARDIAN _____ PHYSICIAN _____

YES NO

1. _____ Any chronic or recurrent illnesses?
2. _____ Any illness lasting more than a week?
3. _____ Any hospitalizations?
4. _____ Any surgery other than tonsillectomy?
5. _____ Any injuries requiring treatment by a physician?
6. _____ Presently taking any medications?
7. _____ Any problems with blood pressure or heart?
8. _____ Any dizziness, fainting, convulsions or frequent headaches?
9. _____ Have you ever "passed out" or been "knocked out"?
10. _____ Wear eyeglasses or contact lenses?
11. _____ Wear any dental appliance such as braces, bridge or plate?
12. _____ Allergic to ANY medication (aspirin, penicillin, etc.)?
13. _____ Any knee or ankle injury and/or surgery?
14. _____ Been diagnosed with a concussion? Date? (mth/yr) _____
15. _____ Any history of neck injury?
16. _____ Any other joint sprains or dislocations (shoulder, wrist, finger, etc.)?
17. _____ Any broken bones (fractures)?
18. _____ Any organ missing other than tonsils (appendix, eye, kidney, testicles)?
19. _____ Any heat exhaustion or heat stroke?
20. _____ Any reasons why this applicant should not participate in sports?
21. _____ Any menstrual problems?
22. _____ Do you have to stop while running twice around a 1/4 mile track?
23. _____ Have any family history of "heart problems" under age 50?

PARENTAL PERMISSION I give my permission for the above-named child to participate in the sport(s) approved by the examiner under the auspices of the Shoreline School District and authorize the coach or other responsible official to obtain emergency medical care for my child should such become necessary during participation and I am not immediately available.

DATE _____ PARENT/GUARDIAN _____

EXAMINER'S COMMENTS ON HISTORY ("yes" answers above):

Exam Date _____ **PHYSICAL EXAMINATION**

HEIGHT _____ inches **WEIGHT** _____ Pounds **M** ___ **F** ___ **AGE** _____ Years

PULSE ___ **BLOOD PRESSURE** _____ **VISUAL ACUITY:** Left 20/
Right 20/

HEARING Left ___ Right ___

NORMAL	ABNORMAL*	NORMAL	ABNORMAL*
<input type="checkbox"/> 1. Head	<input type="checkbox"/>	<input type="checkbox"/> 9. Neurological	<input type="checkbox"/>
<input type="checkbox"/> 2. Eyes (Pupils), ENT	<input type="checkbox"/>	<input type="checkbox"/> 10. Skin	<input type="checkbox"/>
<input type="checkbox"/> 3. Teeth	<input type="checkbox"/>	<input type="checkbox"/> 11. Physical Maturity	<input type="checkbox"/>
<input type="checkbox"/> 4. Chest	<input type="checkbox"/>	<input type="checkbox"/> 12. Spine, back	<input type="checkbox"/>
<input type="checkbox"/> 5. Lungs	<input type="checkbox"/>	<input type="checkbox"/> 13. Upper Extremities	<input type="checkbox"/>
<input type="checkbox"/> 6. Heart	<input type="checkbox"/>	<input type="checkbox"/> 14. Lower Extremities	<input type="checkbox"/>
<input type="checkbox"/> 7. Abdomen	<input type="checkbox"/>	<input type="checkbox"/> 15. Urinalysis	<input type="checkbox"/>
<input type="checkbox"/> 8. Genitalia	<input type="checkbox"/>		

* Describe findings _____

List any immunizations given at this visit _____

Recommendation:

I certify that I have examined this pupil on the date above and find him/her physically able to compete in supervised interscholastic activities as described below.

- No contraindications to FULL participation
- Has following limitations but may participate:

Participation contraindicated for following reasons:

Student may participate in ACTIVITIES NOT CROSSED OUT BELOW for the next 24 months, which could include middle school & high school competition.

BASEBALL BASKETBALL CROSS COUNTRY DRILL FOOTBALL GOLF
WRESTLING GYMNASTICS SOCCER SOFTBALL SWIMMING TENNIS TRACK
CHEER VOLLYBALL OTHER _____

Date of Signing: _____ EXAMINER'S SIGNATURE _____

Examiner's Stamp EXAMINER'S NAME _____

TITLE _____

PHONE _____