

**FEDERAL WAY PUBLIC SCHOOLS
PREPARTICIPATION HISTORY AND PHYSICAL EXAMINATION**

Name: _____ Birth Date: _____ Exam Date: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Sport(s): _____

HISTORY

Yes No (Please check appropriate line)

- 1. a. ___ ___ Have you had any illness/injury recently, or do you have an illness/injury now?
- b. ___ ___ Have you had a medical problem, illness or injury since your last exam?
- c. ___ ___ Do you have any chronic or recurrent illness?
- d. ___ ___ Have you ever had any illness lasting more than a week?
- e. ___ ___ Have you ever been hospitalized overnight?
- f. ___ ___ Have you had any surgery other than tonsillectomy?
- g. ___ ___ Have you ever had any injuries requiring treatment by a physician?
- h. ___ ___ Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc.)?
- 2. ___ ___ Are you presently taking ANY medications (including vitamin, aspirin, etc.)?
- 3. ___ ___ Do you have ANY allergies (medicines, bees, foods, or other factors)?
- 4. a. ___ ___ Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?
- b. ___ ___ Do you tire more easily or quickly than your friends during exercise?
- c. ___ ___ Have you ever had any problem with your blood pressure or your heart?
- d. ___ ___ Have any close relatives had heart problems, heart attack or sudden death before they were age 50?
- 5. ___ ___ Do you have any skin problems (acne, itching, rashes, etc.)?
- 6. a. ___ ___ Have you ever had fainting, convulsions, seizures or severe dizziness?
- b. ___ ___ Do you have frequent severe headaches?
- c. ___ ___ Have you ever had a "stinger" or "burner" or "pinched nerve"?
- d. ___ ___ Have you ever been "knocked out" or "passed out"?
- e. ___ ___ Have you ever had a neck or head injury?
- 7. ___ ___ Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems?
- 8. ___ ___ Have you had asthma, or trouble breathing, or cough during or after exercise?
- 9. a. ___ ___ Do you wear eyeglasses, contact lenses or protective eye wear?
- b. ___ ___ Have you had any problem with your eyes or vision?
- 10. ___ ___ Do you wear any dental appliance such as braces, bridge, plate, retainer?
- 11. a. ___ ___ Have you ever had a knee injury?
- b. ___ ___ Have you ever had an ankle injury?
- c. ___ ___ Have you ever injured any other joint (shoulder, wrist, fingers, etc.)?
- d. ___ ___ Have you ever had a broken bone (fracture)?
- e. ___ ___ Have you ever had a cast, splint, or had to use crutches?
- f. ___ ___ Must you use special equipment for competition (pads, braces, neck roll, etc.)?
- 12. ___ ___ Has it been more than 5 years since your last tetanus booster shot?
- 13. ___ ___ Are you worried about your weight?
- 14. ___ ___ FEMALES: Have you any menstrual problems?
- 15. ___ ___ 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):

**SIDE B – HEALTH CARE PROVIDER TO COMPLETE
PHYSICAL EXAMINATION**

Optional

Age: _____ Pulse: _____
Height: _____ Blood Pressure: _____
Weight: _____ Visual Acuity: Left 20/ _____
Right 20/ _____

Urinalysis:

Body Fat %

HCT:

EST VO2 Max:

Audiometry:

(Please check appropriate line)

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"/>	_____

Assessment: Full participation **For athletic program:** JH HS Both
 Limited participation (describe limitations, restrictions):

Participation contraindicated (list reasons):

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

DATE: _____ EXAMINER'S SIGNATURE: _____

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