

# SEQUIM SCHOOL DISTRICT NO. 323 SPORTS PREPARTICIPATION EXAM REPORT

History

Name \_\_\_\_\_ Grade \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_ Family Physician \_\_\_\_\_

In case of emergency, notify:

Name \_\_\_\_\_ Address \_\_\_\_\_ Telephone \_\_\_\_\_

Date of last tetanus booster \_\_\_\_\_ Date of last examination by a doctor \_\_\_\_\_

The following questions are to be answered by either yes or no. Please check the appropriate space.

	Yes	No		Yes	No
Have you been under a doctor's care in the past 12 months?	( )	( )	Have you had or do you now have: Back injury or frequent backaches?	( )	( )
Have you been in the hospital in the past 12 months?	( )	( )	Knee injury (sprain) or recurrent pain?	( )	( )
Have you ever had any type of surgery?	( )	( )	Ankle injury (sprain) or recurrent pain?	( )	( )
Do you want to talk to a doctor about a health problem or an injury?	( )	( )	Other joint problems (e.g., swelling, pain, decreased range of motion)?	( )	( )
Has anyone in your immediate family ever had: Diabetes (high sugar in blood)?	( )	( )	Bone infection?	( )	( )
Allergies (hay fever or asthma)?	( )	( )	Have you had or do you now have: Diabetes (high sugar in blood or urine)?	( )	( )
Migraine headaches?	( )	( )	Tendency to bleed or bruise easily?	( )	( )
Heart trouble?	( )	( )	Anemia ("tired" blood)?	( )	( )
High blood pressure?	( )	( )	Weight problem (under or overweight)?	( )	( )
Has anyone in your family, under age 50, died suddenly?	( )	( )	Have you had or do you now have: Asthma (wheezing)?	( )	( )
Have you had or do you now have: Brain concussion (head injury)?	( )	( )	Hay fever?	( )	( )
Tendency to lose consciousness (faint)?	( )	( )	Hives or rash?	( )	( )
Skull fracture?	( )	( )	Bee-sting reactions (allergy)?	( )	( )
Convulsions or epilepsy?	( )	( )	Reaction to medicine (allergy)?	( )	( )
Neck injury?	( )	( )	Do you: Smoke?	( )	( )
Have you had or do you now have: Very bad (impaired) vision in one eye?	( )	( )	Take any medicine regularly? If YES, name of medication _____	( )	( )
Temporary loss of vision?	( )	( )	Take medicine for emergency use? If YES, name of medication _____	( )	( )
To wear glasses or contact lenses?	( )	( )	Have you had or do you now have: Heart trouble or murmur?	( )	( )
Have you had or do you now have: Hearing loss?	( )	( )	High blood pressure?	( )	( )
Perforated eardrum?	( )	( )	Persistent cough?	( )	( )
Discharge from ear(s) (recurrent infections)?	( )	( )	Chest pain with exercise?	( )	( )
Sinus infections?	( )	( )	Dizziness or faintness with exercise?	( )	( )
Broken nose?	( )	( )	Have you had or do you now have: Recurrent rash?	( )	( )
Dental plate (dentures)?	( )	( )	Fungus infection?	( )	( )
Orthodontia (teeth straightened)?	( )	( )	Athlete's foot?	( )	( )
Have you had or do you now have: Hernia?	( )	( )	Recurrent boils (skin infection)?	( )	( )
Kidney problems?	( )	( )	Do you wish to discuss an emotional problem with the doctor?	( )	( )
Loss of function/absence of testicles (boys)?	( )	( )	Have you ever been told to give up sports because of a health problem?	( )	( )
Menstrual problems (girls)? Age at onset of menstruation _____	( )	( )	If you have answered yes to any of the above questions, please explain below: _____ _____		
Have you had or do you now have: Bone fracture?	( )	( )			
Joint dislocation?	( )	( )			
Foot problems?	( )	( )			
To wear a cast?	( )	( )			

I certify that the above information is correct, and give permission for my child to participate in interscholastic sports.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Please be advised that the pre-participation screening physical examination in no way constitutes a complete physical examination.

# PHYSICAL EXAMINATION

1. Height \_\_\_\_\_ Weight \_\_\_\_\_
2. Blood Pressure (sitting) \_\_\_\_\_
3. Vision: Left 20/ \_\_\_\_\_ Right 20/ \_\_\_\_\_

Check if  
within normal  
limits

- |                      |       |     |
|----------------------|-------|-----|
| 4. Skin              | ..... | ( ) |
| 5. Mouth             | ..... | ( ) |
| 6. Eyes              | ..... | ( ) |
| 7. Ears              | ..... | ( ) |
| 8. Neck              | ..... | ( ) |
| 9. Lymphatics        | ..... | ( ) |
| 10. Respiratory      | ..... | ( ) |
| 11. Cardiovascular   | ..... | ( ) |
| Heart                | ..... | ( ) |
| Pulses               | ..... | ( ) |
| 12. Abdomen          | ..... | ( ) |
| 13. Genitalia        | ..... | ( ) |
| 14. Extremities      | ..... | ( ) |
| 15. Neurologic       | ..... | ( ) |
| Reflexes             | ..... | ( ) |
| 16. Orthopedic       | ..... | ( ) |
| Cervical spine/back  | ..... | ( ) |
| Arm/elbow/wrist/hand | ..... | ( ) |
| Knees                | ..... | ( ) |
| Ankles               | ..... | ( ) |

## **PHYSICIAN'S STATEMENT OF HEALTH**

Those licensed to perform physical examinations include a Medical Doctor (MD), Doctor of Osteopathy (DO), Advanced Registered Nurse Practitioner (ARNP), Physician's Assistant (PA), and Naturopathic Physician.

I certify that I have examined \_\_\_\_\_ and have found no gross evidence of any abnormality that will interfere with his or her participation.

\_\_\_\_\_, MD, DO, ARNP, or PA  
Date Signature

\_\_\_\_\_  
Name of Physician (Please Print)

\_\_\_\_\_  
Name of Clinic

\_\_\_\_\_  
Telephone Number