



# PIERCE COUNTY HEALTH REPORT

**TIME OF EXAMINATION:** *For athletics, exams must be given during the 24-month period prior to first participation in interscholastic athletics in middle school and prior to participation in high school. Clearance for continued participation is to be provided on this form prior to each subsequent year of interscholastic athletics. A yearly clearance from the examiner is needed for continued participation.*

**CHOICE OF EXAMINER:** *It is recommended that each child have a personal physician knowledgeable regarding each aspect of his/her health. Examination may be performed by a licensed physician (MD or FO), a licensed physician's assistant or a certified pediatric or family nurse practitioner working under the direction of a physician whose name is to be stated.*

THIS SECTION TO BE COMPLETED BY THE PARENT OR GUARDIAN BEFORE EXAMINATION BY THE PHYSICIAN. PLEASE PRINT.

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Sex  M  F  
 Birthdate (Month/Day/Year) \_\_\_\_\_ Name of School, Camp, Organization \_\_\_\_\_  
 Parent/Guardian Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 Physician \_\_\_\_\_ Phone \_\_\_\_\_ Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Circle Choices **SCHOOL** - Preschool ChildFind Head Start ECEAP Kindergarten Elementary School Middle School High School  
 To enter grade: \_\_ September 20\_\_ **INTERSCHOLASTIC ACTIVITIES** - Baseball Basketball Cross Country Football Gymnastics  
 Soccer Swimming Tennis Track Volleyball Wrestling **OTHER** - Daycare Development Center Child Study Park Board Recreation  
 Boys Club Camp Lifesaving Other (specify) \_\_\_\_\_

IS THERE ANY ILLNESS, DISABILITY, LIFE THREATENING CONDITION or other situation which might affect performance? *Please explain.*  
 \_\_\_\_\_

CHILD HAS THE FOLLOWING *Circle the appropriate item(s) and explain on the right. Name other doctors important in child's care* \_\_\_\_\_

SKIN: acne, eczema ORTHOPEDIC: fracture or sprain, scoliosis, congenital hip  
 VISION: glasses, contacts NEUROLOGICAL: convulsions, meningitis, cerebral palsy  
 HEARING: aids METABOLIC: diabetes  
 NOSE: bleeding BLOOD: anemia, sickle cell disease  
 MOUTH: dental decay, orthodontia ALLERGIES:  Food \_\_\_\_\_  insect \_\_\_\_\_  pollen \_\_\_\_\_  peanut \_\_\_\_\_  
 LUNGS: asthma, bronchitis  contact \_\_\_\_\_  drugs \_\_\_\_\_  other (specify) \_\_\_\_\_  
 HEART: congenital, rheumatic HOSPITALIZATION(S) (year and reason) \_\_\_\_\_  
 GASTROINTESTINAL: ulcer, colitis, hepatitis OPERATION(S) (year and reason) \_\_\_\_\_  
 GENITOURINARY: kidney or bladder infection DISABILITY: physical mental behavioral social learning vision hearing speech ADHA  
 If female, menstruating  Yes  No HAS CHILD HAD: rubeola rebella mumps chicken pox whooping cough  
 If child is under 3 years, give birthweight \_\_\_\_\_ Describe unusual factors regarding birth or health immediately after birth \_\_\_\_\_

IMMUNIZATIONS	NONE	DOSES RECEIVED					MONTH/DAY/YEAR
		1	2	3	4	5 or more	
Diphtheria, Tetanus, Pertussis, Any Combination of DTaP <input type="checkbox"/> DTaP <input type="checkbox"/> TD (check dose given)							
Oral Polio Vaccine (OPV) Injectable Polio Vaccine (IPV) <input type="checkbox"/> OPV <input type="checkbox"/> IPV (check dose given)							
MMR (Measles, Mumps, Rubella)							
Hemophilus Influenza B Vaccine							
Hepatitis B							
Varicella							



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*(Continued)*

THIS SECTION IS THE RESPONSIBILITY OF THE PHYSICIAN. PARENT(S) SHOULD BE PRESENT FOR EXAMINATION.

Date of Examination \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Hearing:  Right  Left  
 Tympanogram:  Right  Left Hematocrit \_\_\_\_\_ Hemoglobin \_\_\_\_\_ Sickle Cell \_\_\_\_\_ Urinalysis \_\_\_\_\_  
 Vision: Right 20/\_\_\_ Left 20/\_\_\_ Vision Corrected: Right 20/\_\_\_ Left 20/\_\_\_  Glasses  Contacts (*check one*) Color Vision \_\_\_\_\_  
 Tuberculosis Risk Screen:  Low  \*High (*check one*) \*Tuberculosis Skin Test: Date \_\_\_\_\_ Type \_\_\_\_\_ Result \_\_\_\_\_

CIRCLE ABNORMAL AREAS (*discuss at right*)

Appearance	Scalp	Throat	Neurological
Development	Head	Chest	Dental
Nutrition	Eyes	Lungs	Genitalia
Acne	Ears	Heart	Extremities
Rashes	Nose	Abdomen	Back ( <i>shows no evidence of Kyphosis or Scoliosis</i> )

CIRCLE ANY CONDITION

Eczema	Allergy	Obesity	Asthma/Exercise Induced Asthma
Lung	Heart	Orthopedic	Diabetes

Other: \_\_\_\_\_

An additional narrative report is attached or will be forwarded?  Yes  No (*check one*)

INTERVAL NOTE: Identify any occurrences since examination which could affect participation in school, athletics or other activities

\_\_\_\_\_

REFERRAL(S)  Eye  Ear  Dental  Orthopedic  Other (*describe*) \_\_\_\_\_

Parents need to help to obtain  Yes  No Please name other doctors involved in care of child: \_\_\_\_\_

RECOMMENDED PHYSICAL ACTIVITY

Full day care, preschool, physical education, sports or camp

Swimming

Modified or restricted activity (*describe*) \_\_\_\_\_

Interscholastic athletics. If wrestling, not to go below what weight? \_\_\_\_\_ lbs

Minimum Weight - REQUIRED FOR WRESTLERS ONLY (*check one*) 101 108 115 122 129 135 141 148 158 168 178 188 Unlimited

*A physician's written release is required to resume participation following an illness and or injury serious enough to require medical care. Give details above.*

Date signed \_\_\_\_\_ Next recommended date of examination \_\_\_\_\_ Physician's Name \_\_\_\_\_  
*(please print or stamp)*

Signature and Title \_\_\_\_\_ Phone \_\_\_\_\_