ENUMCLAW HIGH SCHOOL

Physical Evaluation Form

Student Name _____ AGE ___ DOB___/___/___ Gender: ☐M ☐F

School _____ Grade _____ Teacher/Advisor/Coach _____

Parent/Guardian Name _____ Phone H) _____ W) _____ C) _____

Parent/Guardian Name _____ Phone H) _____ W) _____ C) _____

Address, City, Zip _____

Licensed Health Care Provider _____ Phone _____

Medical Concerns

	Yes	No	
Asthma	☐	☐	
Diabetes	☐	☐	
Seizure Disorder	☐	☐	Date of last seizure: _____
Latex Allergy	☐	☐	
Allergic Reactions (plant, insect, food, medicine)	☐	☐	Type/emergency medication: _____
Recent exposure to contagious disease	☐	☐	Disease: _____
Safety Concerns/Sleepwalking/Fainting	☐	☐	If yes, explain: _____
Special Dietary Needs	☐	☐	If yes, explain: _____
Other	☐	☐	If yes, explain: _____
Is student currently taking medication	☐	☐	If yes, list medications needed for this activity: _____

Other information or direction from parent: _____

Parent Signature: _____ **Date:** _____

PHYSICAL EXAMINATION FOR PHYSICIAN USE ONLY

Age: _____ Pulse: _____ Blood Pressure: _____ Height: _____ Weight: _____

FOR WRESTLERS ONLY: Minimum Wrestling Weight:_____Visual Acuity: Left 20/_____ Right 20/_____

Normal			Abnormal	Normal			Abnormal
☐	1.	Head	☐	☐	8.	Genitalia	☐
☐	2.	Eyes (pupils), ENT	☐	☐	9.	Neurologic	☐
☐	3.	Teeth	☐	☐	10.	Skin	☐
☐	4.	Chest	☐	☐	11.	Physical Maturity	☐
☐	5.	Lungs	☐	☐	12.	Spine, Back	☐
☐	6.	Heart	☐	☐	13.	Shoulders, Upper extremities	☐
☐	7.	Abdomen	☐	☐	14.	Lower extremities	☐

Limited participation (describe limitations, restrictions): _____

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

Examiner's Signature: _____ **Date**: _____

Print Examiner's Name:_____ **Examiner's Phone**: _____

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