Mercer Island High School

ATHLETIC HEALTH FORM

To be filled out by the student/parent

Student _____ Birth Date _____ Grade _____ Gender _____

Address _____ Hm. Phone _____ Wk. Phone _____

Physician's Name (Please Print) _____ Phone _____

Physician's Address _____

Date of last Tetanus Immunization? _____ Date of last Measles Immunization? _____

Explain "Yes" answers below	No	Yes
1. Overnight hospitalizations, operations or surgery? Dates	O	O
2. Are you presently taking any medication or pills?	O	O
3. Do you have any allergies (medicine, bees or other stinging insects?)	O	O
4. Have you ever passed out during or after exercise?	O	O
Have you ever been dizzy during or after exercise?	O	O
Do you tire more quickly than your friends during exercise?	O	O
Have you ever had high blood pressure?	O	O
Have you ever been told that you have a heart murmur?	O	O
Have you ever had racing of your heart or skipped heartbeats?	O	O
Anyone under 50 yrs old in the family die of heart problems?	O	O
5. Do you have any skin problems?	O	O
6. Have you ever had a head injury?	O	O
Have you ever been knocked out or unconscious?	O	O
Have you ever had a seizure?	O	O
Have you ever had a stinger, burner or pinched nerve?	O	O
7. Have you ever had heat or muscle cramps?	O	O
Have you ever been dizzy or passed out in the heat?	O	O
8. Do you have trouble breathing or do you cough during or after activity?	O	O
9. Do you use any special equipment (pads, braces, mouth guard, etc?	O	O
10. Have you had any problems with your eyes or vision?	O	O
Do you wear glasses or contacts or protective eye or vision?	O	O
11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?	O	O

o Head o Shoulder o Thigh o Neck o Elbow o Knee o Chest o Foot

o Forearm o Shin/calf o Back o Wrist o Ankle o Hip o Hand

12. Females Only: Have your menses begun? _____

Do they come more often than once a month?_____ Less often than every two months?_____

Explain "Yes" answers to Questions 1-12 above: _____

_____

_____

The signature below indicates that a parent/guardian and the participating student acknowledge they have carefully read this form and the above information is true.

STUDENT SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

Mercer Island High School

PHYSICAL EXAMINATION

To be completed by a physician with signature for sports clearance once each school year
Mercer Island School District requires a physical exam every two years for sports participation

Name: _____ Date: _____

Height: _____ Weight: _____ BP:_____ /_____ Pulse: _____

Vision: R 20/_____ L 20/_____ Corrected: Y N Pupils _____

	Normal	Abnormal Findings	Initials
Cardiopulmonary			
Pulse			
Heart			
Lungs			
Skin			
Abdominal			
Genitalia			
Musculoskeletal			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			
Other			

Clearance:

A. Cleared

B. Cleared after completing evaluation/rehabilitation for: _____

C. Not Cleared for: Collision O

Contact O

Activity level O _____ Strenuous _____ Moderately strenuous _____ Non strenuous

Due to: _____

Recommendation: _____

_____

_____

Name of Physician: (PLEASE PRINT) _____ Phone: _____

Physician's Signature: _____ Date of Exam: _____

Date of Signature: _____

For office use only
Exam Exp: _____

Clearance Exp: _____