THE WEBB SCHOOL
BELL BUCKLE

HISTORY AND PHYSICAL EXAMINATION

Note: The first 2 pages of this form should be filled out by the patient and/or parent ***prior*** *to seeing the physician.*
The physician should complete the remaining pages.
If you plan to participate in any sports, please be aware that this form must be completed ***after April 15th.***

Name: ______________________________ **Date of birth:** ______________

Date of Exam: ____________ **Gender:** __________ **Age:** ______ **Grade:** ______ **Sport(s) if applicable:** ______________________________

List past and current medical conditions: ______________________________

Have you ever had surgery? If yes, list all past surgical procedures: ______________________________

Medications and supplements: List all current prescriptions, over-the-counter, and supplements (herbal and nutritional): ______________________________

Do you have any allergies? If yes, please list (i.e. medications, seasonal, food, stinging insects): ______________________________

Have you received any COVID-19 vaccines? ☐ No
☐ Yes: ☐ 1 dose ☐ 2 doses ☐Booster Date of last vaccine (mm/yyyy):____________

Explain "Yes" answers at the bottom of page 2. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions or recent illness?		
3. Do you have any concerns you would like to discuss with your provider?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
4. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
9. Do you get lightheaded or feel more short of breath than expected during exercise?		
10. Have you ever had a seizure?		
11. Do you get lightheaded or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
12. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
13. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
14. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
15. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		

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BONE AND JOINT QUESTIONS	Yes	No
16. Have you ever had an injury to a bone, muscle, ligament, or tendon that resulted in physical activity restrictions?		
17. Do you have a bone, muscle, tendon, ligament, or joint injury that bothers you?		
18. Do you have any history of juvenile arthritis or connective tissue disease?		
MEDICAL QUESTIONS	Yes	No
19. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
20. Have you ever used an inhaler or taken asthma medicine?		
21. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
22. Do you have groin pain or a painful bulge or hernia in the groin area?		
23. Have you had infectious mononucleosis (mono) within the last month?		
24. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
25. Have you ever had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
26. Do you have a history of seizure disorder?		
27. Do you have headaches with exercise?		
28. Have you ever had numbness, tingling, or weakness in your arms or legs or been unable to move your arms or legs after being hit or falling?		
29. Have you ever become ill while exercising in the heat?		
30. Do you or someone in your family have sickle cell trait or disease? Unsure		
31. Have you had any problems with your eyes or vision, had an eye injury, or wear contacts/glasses?		
32. Do you worry about your weight?		
33. Are you trying to or has anyone recommended that you gain or lose weight?		
34. Are you on a special diet or do you avoid certain types of foods?		
35. Have you ever had an eating disorder?		
FEMALES ONLY	Yes	No
36. Have you ever had a menstrual period?		
37. How old were you when you had your first menstrual period?		
38. How many periods have you had in the last 12 months?		

Explain "yes" answers here:

____
____
____
____
____
____
____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of student ______________________________

Signature of parent/guardian ______________________________

Date ______________

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Name: ______________________________ **Date of birth:** ______________

The remainder of this form must be completed by a healthcare professional (MD, DO, NP, or PA).

EXAMINATION		
Height: Weight:		
BP: / Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurological		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		

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MEDICAL	NORMAL	ABNORMAL FINDINGS
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg squat test, box drop or step drop test		

This student is

☐ **Cleared for all sports/physical activities without restriction.**

☐ **Cleared for all sports/physical activities without restriction with recommendations for further evaluation or treatment for:**

____

____

☐ **Cleared for certain sports/physical activities:**

____

____

☐ **Not cleared:**

☐ **Pending further evaluation**

☐ **For any sports/physical activities**

Recommendations

____

____

____

I have examined the above-named student and completed the physical evaluation. The student does not present apparent clinical contraindications to participate in the sport(s)/physical activities as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the student has been cleared for participation, the healthcare provider may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the student (and parents/guardians).

Name of healthcare professional (print)): ______________________________ Date: ____________

Address: ______________________________ Phone: ____________

Signature of healthcare professional: ______________________________, MD, DO, NP, or PA