CAMPBELL COUNTY SCHOOL DISTRICT **Rev. 2014**

SCHOOL PHYSICAL EXAMINATION/ACTIVITIES PARTICIPATION PERMITS

School______________________________ Grade______ Birthdate_____/_____/_____ Male______ Female _______

Name (Last, First, Middle)____ Sport(s) _____________________________

Address____ Home Phone _______________________

Father's Name________________ Phone #_____________ Mother's Name_________________ Phone # ______________

Optional History - Please fill in to the best of your ability. Explain "Yes " answers below. Circle questions you do not know answers to. Answering "YES" to any of the questions below may require you to undergo a complete physical examination by your private physician.

1. Have you had a medical illness or injury since your last check up or sports physical?. . . . . . YES
2. Have you ever been hospitalized overnight?. . . . . . YES
   Have you ever had surgery?. . . . . . YES
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?. . . . . . YES
   Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?. . . . . . YES
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?. . . . . . YES
   Have you ever had a rash or hives develop during or after exercise?. . . . . . YES
5. Have you ever been dizzy or fainted during or after exercise?. . . . . . YES
   Have you ever had chest pain during or after exercise?. . . . . . YES
   Have you had high blood pressure or high cholesterol?. . . . . . YES
   Have you ever been told you have a heart murmur?. . . . . . YES
   Has any family member or relative died of heart problems or of sudden death before age 50?. . . . . . YES
   Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?. . . . . . YES
   Has a physician ever denied or restricted your participation in sports for any heart problems?. . . . . . YES
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?. . . . . . YES
7. Have you ever had a head injury or concussion?. . . . . . YES
   Have you ever been knocked out, become unconscious, or lost your memory?. . . . . . YES
   Have you ever had a seizure?. . . . . . YES
   Do you have frequent or severe headaches?. . . . . . YES
   Have you ever had numbness or tingling in your arms, hands, legs or feet?. . . . . . YES
   Have you ever had a stinger, burner or pinched nerve?. . . . . . YES
8. Have you ever become ill from exercising in the heat?. . . . . . YES
9. Do you cough, wheeze or have trouble breathing during or after activity?. . . . . . YES
   Do you have asthma?. . . . . . YES
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?. . . . . . YES
11. Have you had any problems with your eyes or vision?. . . . . . YES
12. Have you ever had a sprain, strain or swelling after injury?.. . . . . . YES
    Have you broken or fractured any bones or dislocated any joints?. . . . . . YES

If YES, circle the appropriate answer and explain below.

HEAD NECK BACK CHEST SHOULDER UPPER ARM ELBOW FOREARM
WRIST HAND FINGER HIP THIGH KNEE SHIN/CALF ANKLE FOOT

EXPLAIN "YES" ANSWERS HERE:____

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Immunization records are on file with school (circle one): YES NO (if no, please record dates below)
Record the dates of your most recent immunizations (shots) for: Tetanus_______ Measles_______ Hepatitis B_______ Chicken Pox ________

Physician's Examination Record -- (For Doctor's Use Only) -- Please check all blanks. Height________ Weight________
Code: 0 - Normal 1 - Remedial Defect 2 - Defect, but no further treatment necessary. Percent Body Fat__________

1. Urine, Alb.______ Sugar______	6. Teeth ______	11. Thyroid ______	16. Genitalia ______
2. Blood Pressure ______	7. Gums ______	12. Heart ______	17. Arms & Hands ______
3. Pulse ______	8. Throat & Tonsils ______	13. Lungs ______	18. Legs & Feet ______
4. Eyes ______	9. Nose ______	14. Abdomen ______	19. Spine-Posture ______
5. Ears ______	10. Cervical Nodes ______	15. Hernia ______	20. Glasses- Last Fitting ______

Physical Activity: **UNRESTRICTED**______________ **MODIFIED**______________

Reason____

Recommendations____

____

Date____________________ Signature of Medical Doctor____