Northshore School District

Pre-Participation History and Physical Examination (rev. 05/25)

Name (print full name) _____Birth Date_____Student ID#_____ Exam Date _____

Street Address_____ City _____ Zip_____

Home Phone _____ Sport _____ Grade _____ M ❑ F ❑

*Parents/Guardians **must** complete the reverse side before physical appointment.*

MEDICAL AUTHORITIES LICENSED TO GIVE PHYSICAL EXAMINATIONS

❑ Medical Doctor (MD) ❑ Certified Nurse Practitioner (CRN) ❑ Naturopaths (ND)
❑ Doctor of Osteopathy (DO) ❑ Medics-Physician Assistant (PA)

Age _____ Pulse_____ Blood Pressure _____ ⇓ This Section Optional ⇓

Height_____ Weight _____ Urinalysis_____
Body Fat% _____

Visual Acuity: Left: 20/ _____ Right: 20/_____ HCT _____

Normal	**Abnormal**
❑ Head	❑ _____
❑ Eyes (pupils), ENT	❑ _____
❑ Teeth	❑ _____
❑ Chest	❑ _____
❑ Lungs	❑ _____
❑ Heart	❑ _____
❑ Abdomen	❑ _____
❑ Genitalia	❑ _____
❑ Neurological	❑ _____
❑ Skin	❑ _____
❑ Physical Maturity	❑ _____
❑ Spine, Back	❑ _____
❑ Shoulders, Upper extremities	❑ _____
❑ Lower extremities	❑ _____

Assessment

❑ Full participation

❑ Limited participation (describe limitations, restrictions) _____

❑ **Life threatening condition (severe asthma, bee/food allergy) requires medication order <u>before</u> participation. (Please attach the information/medication orders.)**

_____

_____

❑ Participation contradicted (list reasons)

_____

_____

Recommendations (equipment, taping, rehabilitation, etc.)

_____

_____

Examiner's Certification

Authorized examiners are medical authorities licensed to give medical examinations. (WIAA 18.13.1)

I hereby certify that the above-named individual is physically qualified to participate in all interscholastic athletic activities NOT CROSSED OUT BELOW:

Badminton Baseball Basketball Cheer Cross Country Fastptich Flag Football Football Golf Gymnastics Lacrosse Rowing Slowpitch Soccer Swim/Dive Tennis Track Unified Bowling Unified Soccer Volleyball Water Polo Wrestling

Wrestling Weight Permit: Circle **<u>lowest</u>** weight classifications permissible

Senior High	103	112	119	125	130	135	140	145	152	161	171	189	215	275
Junior High	75	80	85	90	95	100	105	110	115	120	125	130	135	140
							152	162	172	185	Unlimited (must be over 185)			

Examiner's Name (print) _____ Examiner's Phone (____) _____

Examiner's Signature _____ Date _____

Name: Birthdate:

Pre-Participation History

Yes	No	
❑	❑	Have you had any illness/injury recently, or do you have an illness/injury now?
❑	❑	Have you had a medical problem, illness, or injury since your last exam?
❑	❑	Do you have any chronic or recurrent illness?
❑	❑	Have you ever had any illness lasting more that a week?
❑	❑	Have you ever been hospitalized overnight?
❑	❑	Have you had any surgery other than tonsillectomy?
❑	❑	Have you ever had any injuries requiring treatment by a physician?
❑	❑	Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc)?
❑	❑	Are you presently taking ANY medications (including birth control pills, vitamins, aspirin, etc.)?
❑	❑	Do you have ANY allergies (medicines, bees, foods, or other factors)?
❑	❑	Have you ever had chest pain, dizziness, faintness, passing out during or after exercise?
❑	❑	Do you tire more easily or quickly than your friends during exercises?
❑	❑	Have you ever had any problem with your blood pressure or your heart?
❑	❑	Have any close relatives had heart problems, heart attack, or sudden death before they were age 50?
❑	❑	Do you have any skin problems (acne, itching, rashes, etc.)?
❑	❑	Have you ever had fainting, convulsions, seizures, or severe dizziness?
❑	❑	Do you have frequent severe headaches?
❑	❑	Have you ever had a “stinger” or “burner” or “pinched nerve”?
❑	❑	Have you ever been “knocked out” or “passed out”?
❑	❑	Have you ever had a neck or head injury?
❑	❑	Have you ever had heat exhaustion, heat stroke, heat cramps, or similar heat-related problems?
❑	❑	Have you had asthma, or trouble breathing, or cough during or after exercise?
❑	❑	Do you wear eyeglasses, contact lenses, or protective eye wear?
❑	❑	Have you had any problems with your eyes or vision?
❑	❑	Do you wear any dental appliances such as braces, bridge, plate, retainer?
❑	❑	Have you ever had a knee injury?
❑	❑	Have you ever had an ankle injury?
❑	❑	Have you ever injured any other joint (shoulder, wrist, fingers, etc.)?
❑	❑	Have you ever had a broken bone (fracture)?
❑	❑	Have you ever had a cast, splint, or had to use crutches?
❑	❑	Must you use special equipment for competition (pads, braces, neck roll, etc.)?
❑	❑	Has it been more that 5 years since your last tetanus booster shot?
❑	❑	Are you worried about your weight?
❑	❑	FEMALES: Have you any menstrual problems?
❑	❑	Have you any medical concerns about participating in your sport?

Recommendations

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