Current Sport _____ SHORELINE SCHOOL DISTRICT

Sport Physical is good from 24 months based on the **date of the actual physical exam** by the Health care practitioner. 1/14

PLEASE KEEP A COPY FOR YOUR RECORDS

SECONDARY STUDENT HEALTH REPORT

All sections outlined in bold boxes are to be completed by health care provider

HEALTH HISTORY Completed by Parent/Guardian

NAME_____BIRTHDATE_____GRADE_____

ADDRESS_____PHONE_____

PARENT/GUARDIAN_____PHYSICIAN_____

	YES	NO	
1.	____	____	Any chronic or recurrent illnesses?
2.	____	____	Any illness lasting more than a week?
3.	____	____	Any hospitalizations?
4.	____	____	Any surgery other than tonsillectomy?
5.	____	____	Any injuries requiring treatment by a physician?
6.	____	____	Presently taking any medications?
7.	____	____	Any problems with blood pressure or heart?
8.	____	____	Any dizziness, fainting, convulsions or frequent headaches?
9.	____	____	Have you ever "passed out" or been "knocked out"?
10.	____	____	Wear eyeglasses or contact lenses?
11.	____	____	Wear any dental appliance such as braces, bridge or plate?
12.	____	____	Allergic to ANY medication (aspirin, penicillin, etc.)?
13.	____	____	Any knee or ankle injury and/or surgery?
14.	_____	____	Been diagnosed with a concussion? Date? (mth/yr) _____
15.	____	____	Any history of neck injury?
16.	____	____	Any other joint sprains or dislocations (shoulder, wrist, finger, etc.)?
17.	____	____	Any broken bones (fractures)?
18.	____	____	Any organ missing other than tonsils (appendix, eye, kidney, testicles)?
19.	____	____	Any heat exhaustion or heat stroke?
20.	____	____	Any reasons why this applicant should not participate in sports?
21.	____	____	Any menstrual problems?
22.	____	____	Do you have to stop while running twice around a 1/4 mile track?
23.	____	____	Have any family history of "heart problems" under age 50?

PARENTAL PERMISSION I give my permission for the above-named child to participate in the sport(s) approved by the examiner under the auspices of the Shoreline School District and authorize the coach or other responsible official to obtain emergency medical care for my child should such become necessary during participation and I am not immediately available.

DATE_____ PARENT/GUARDIAN_____

EXAMINER'S COMMENTS ON HISTORY ("yes" answers above):

Exam Date_____ **PHYSICAL EXAMINATION**

HEIGHT_____**WEIGHT**_____**AGE** _____

PULSE____ **BLOOD PRESSURE**_____

HEARING Left Right

VISUAL ACUITY: Left 20/ Right 20/

STUDENTS BIOLOGICAL SEX M: ____ **F:**____

NORMAL	ABNORMAL*	NORMAL	ABNOMAL*
( ) 1. Head	( )	( ) 9. Neurological	( )
( ) 2. Eyes (Pupils), ENT	( )	( ) 10. Skin	( )
( ) 3. Teeth	( )	( ) 11. Physical Maturity	( )
( ) 4. Chest	( )	( ) 12. Spine, back	( )
( ) 5. Lungs	( )	( ) 13. Upper Extremities	( )
( ) 6. Heart	( )	( ) 14. Lower Extremities	( )
( ) 7. Abdomen	( )	( ) 15. Urinalysis	( )
( ) 8. Genitalia	( )		

* Describe findings _____

List any immunizations given at this visit_____

Recommendation:

I certify that I have examined this pupil on the date above and find him/her physically able to compete in supervised interscholastic activities as described below.

( ) No contraindications to FULL participation

( ) Has following limitations but may participate:

( ) Life threatening condition (asthma/severe allergy/requires medication/etc)

( ) Participation contraindicated for following reasons:

Student may participate in ACTIVITIES NOT CROSSED OUT BELOW for the next 24 months, which could include middle school & high school competition.

BASEBALL BASKETBALL CROSS COUNTRY DRILL FOOTBALL GOLF WRESTLING GYMNASTICS SOCCER SOFTBALL SWIMMING TENNIS TRACK CHEER VOLLYBALL OTHER_____

Date of Signing:_____ EXAMINER'S SIGNATURE_____

Examiner's Stamp EXAMINER'S NAME_____

TITLE_____

PHONE_____