

PRE-PARTICIPATION HISTORY

The Issaquah School District requires a physical annually. Incoming 9th graders must have a physical dated after June 1, 2011

Student's Name: _____ Grd: _____ Date: _____

- | | | | |
|--------------------------|--------------------------|------|---|
| YES | NO | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. a | Have you had any illness/injury recently, or do you have an illness /injury now? |
| <input type="checkbox"/> | <input type="checkbox"/> | b | Have you had a medical problem, illness or injury since your last exam? |
| <input type="checkbox"/> | <input type="checkbox"/> | c | Do you have any chronic or recurrent illnesses? |
| <input type="checkbox"/> | <input type="checkbox"/> | d | Have you ever had any illness lasting more than a week? |
| <input type="checkbox"/> | <input type="checkbox"/> | e | Have you ever been hospitalized overnight? |
| <input type="checkbox"/> | <input type="checkbox"/> | f | Have you had any surgery other than a tonsillectomy? |
| <input type="checkbox"/> | <input type="checkbox"/> | g | Have you had any injuries requiring treatment by a physician? |
| <input type="checkbox"/> | <input type="checkbox"/> | h | Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc.)? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. | Are you presently taking any medication (including birth control, vitamin, aspirin, etc.)? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. | Do you have any allergies (medicines, bees, food, or other factors)? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. a | Have you ever had chest pain, dizziness, fainting, passing out during or after exercise? |
| <input type="checkbox"/> | <input type="checkbox"/> | b | Do you tire more easily or quickly than your friends during exercise? |
| <input type="checkbox"/> | <input type="checkbox"/> | c | Have you ever had any problem with you blood pressure or your heart? |
| <input type="checkbox"/> | <input type="checkbox"/> | d | Have any relative(s) had heart problems, hear attack or sudden death before they were 50? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. | Do you have any skin problems (acne, itching, rashes, etc.)? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. a | Have you ever had fainting, convulsions, seizures or sever dizziness? |
| <input type="checkbox"/> | <input type="checkbox"/> | b | Do you have frequent severe headaches? |
| <input type="checkbox"/> | <input type="checkbox"/> | c | Have you ever had a "stinger" or "burner" or "pinched nerve"? |
| <input type="checkbox"/> | <input type="checkbox"/> | d | Have you ever been knocked out or passed out? |
| <input type="checkbox"/> | <input type="checkbox"/> | e | Have you ever had a neck or head injury? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. | Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat related problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. | Have you had asthma, or trouble breathing, or coughing during or after exercise? |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. a | Do you wear eyeglasses, contact lenses or protective eye wear? |
| <input type="checkbox"/> | <input type="checkbox"/> | b | Have you ever had any problems with your eyes or vision? |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. | Do you wear any dental appliances such as braces, bridge, plate, retainer, etc.? |
| <input type="checkbox"/> | <input type="checkbox"/> | 11.a | Have you ever had a knee injury? |
| <input type="checkbox"/> | <input type="checkbox"/> | b | Have you ever had an ankle injury? |
| <input type="checkbox"/> | <input type="checkbox"/> | c | Have you ever injured any other joint (shoulder, wrist, fingers, etc.)? |
| <input type="checkbox"/> | <input type="checkbox"/> | d | Have you ever broken a bone or had a fracture? |
| <input type="checkbox"/> | <input type="checkbox"/> | e | Have you ever had a cast, splint, or had to use crutches? |
| <input type="checkbox"/> | <input type="checkbox"/> | f | Are you required to use special equipment for competition (pads, braces, neck roll, etc.)? |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. | Has it been 5 or more years since your last tetanus shot? If so, when: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. | Do you have any worries or concerns regarding your weight? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. | FEMALES: Have you had any menstrual problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. | Have you had any medical concerns about participating in your sport? |

Physician's Stamp

Thank you

PHYSICAL / WELLNESS EXAMINATION (TO BE FILLED OUT BY PHYSICIAN)

*** EXAMINER, write all comments to questions marked "yes" on the back of this page. Reference question number, Thank you***

Height _____ Weight _____ Blood Pressure _____ Age _____ Birth date ____ / ____ / ____

Pulse _____ Visual acuity: Left 20/____ Right 20/____ Wrestling Weight (min Wt.) _____

- | | | | | | | | |
|--------------------------|--|--------------------------|---------------------------------------|--------------------------|--|--------------------------|--|
| <u>Normal</u> | <input type="checkbox"/> 1. Head | <u>Normal</u> | <input type="checkbox"/> 5. Lungs | <u>Normal</u> | <input type="checkbox"/> 9. Neurological | <u>Normal</u> | <input type="checkbox"/> 13. Shoulders, Upp Ext. |
| <input type="checkbox"/> | <input type="checkbox"/> 2. Eyes (pupils), ENT | <input type="checkbox"/> | <input type="checkbox"/> 6. Heart | <input type="checkbox"/> | <input type="checkbox"/> 10. Skin | <input type="checkbox"/> | <input type="checkbox"/> 14. Lower Extremities |
| <input type="checkbox"/> | <input type="checkbox"/> 3. Teeth | <input type="checkbox"/> | <input type="checkbox"/> 7. Abdomen | <input type="checkbox"/> | <input type="checkbox"/> 11. Physical Maturity | <input type="checkbox"/> | <input type="checkbox"/> 15. Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> 4. Chest | <input type="checkbox"/> | <input type="checkbox"/> 8. Genitalia | <input type="checkbox"/> | <input type="checkbox"/> 12. Spine, Back | <input type="checkbox"/> | <input type="checkbox"/> 16. Other _____ |

Areas not checked as 'normal' above need to be identified and explanations given: _____

Overall Assessment: Full Participation Limited Participation (explain) _____

Recommendations: (equipment, taping, rehabilitation) _____

Date: ____ / ____ / ____ Examiner's Signature _____ Phone(____) _____

Print Name of Examiner _____

I hereby provide the District with this complete Pre-participation History & Physical Examination Form for my son/daughter.

DATE _____ SIGNATURE _____
(PARENT / LEGAL GUARDIAN)