

**Must be submitted with the physical*

For Parent/Guardian Use

This form should be completed prior to the physical, signed by parent and student, and available at the time of the physical. If not completed and returned, the school physician may not give final approval to play.

Last Name _____ First _____ D.O.B. _____ Sport: _____
School Yr. _____ Grade _____ School Building _____ Age _____ Sex: M / F

ALL "YES" ANSWERS MUST BE EXPLAINED (BOX AT BOTTOM)

Yes No

		Yes	No
1.	Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Will you be carrying any medication or pills or inhaler in school or sport activities?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Have you ever taken any supplements or vitamins to help you improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Do you have any allergies (for example: to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Have you ever been dizzy or passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Have you ever had high blood sugar (diabetes)?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Do you tire more easily than you feel you should?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Have you ever been diagnosed with anemia?	<input type="checkbox"/>	<input type="checkbox"/>
14.	Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Have you had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
16.	Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
17.	Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>
18.	Have you had a severe viral infection (for example: myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
19.	Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>
20.	Have you ever been diagnosed with blood or bleeding disorders?	<input type="checkbox"/>	<input type="checkbox"/>
21.	Do you have absent one kidney, testicle, eye, or ear?	<input type="checkbox"/>	<input type="checkbox"/>
22.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>
23.	Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
24.	Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
25.	Have you ever had a seizure or convulsion?	<input type="checkbox"/>	<input type="checkbox"/>
26.	Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>
27.	Have you ever had numbness or tingling in your arms, hands, legs, or feet from a stinger, burner, or pinched nerve, or other condition?	<input type="checkbox"/>	<input type="checkbox"/>
28.	Have you ever had heat cramps, heat exhaustion, or heat stroke?	<input type="checkbox"/>	<input type="checkbox"/>
29.	Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>
30.	Do you have asthma or lung disease?	<input type="checkbox"/>	<input type="checkbox"/>
31.	Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
32.	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, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
33.	Have you ever had any problem with your ears or hearing?	<input type="checkbox"/>	<input type="checkbox"/>
34.	Do you wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
35.	Do you have any other problem with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>

		Yes	No
36.	Have you ever had dental health problems or loss of tooth enamel?	<input type="checkbox"/>	<input type="checkbox"/>
37.	Have you broken or fractured any bones or dislocated any joints, or been diagnosed with a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>
38.	Have you ever had a sprain, strain, or swelling after injury or any other problems with pain or swelling in muscles, tendons, bones, or joints that has kept you from participating in sports? <i>If yes, check appropriate box and explain below.</i>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Head <input type="checkbox"/> Back <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Finger <input type="checkbox"/> Thigh <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Foot <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Upper Arm <input type="checkbox"/> Forearm <input type="checkbox"/> Hand <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle		
39.	Have you experienced abdominal discomfort, constipation, diarrhea, and/or bloating?	<input type="checkbox"/>	<input type="checkbox"/>
40.	Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
41.	Has there been any unexplained weight loss or weight gain during the past six months?	<input type="checkbox"/>	<input type="checkbox"/>
42.	Are you uncomfortable with your body weight?	<input type="checkbox"/>	<input type="checkbox"/>
43.	Are you currently following any particular diet or weight reducing plan?	<input type="checkbox"/>	<input type="checkbox"/>
44.	Do you diet frequently?	<input type="checkbox"/>	<input type="checkbox"/>
45.	Do you avoid eating certain food groups?	<input type="checkbox"/>	<input type="checkbox"/>
46.	Have you ever tried to control weight by vomiting, using laxatives, diuretics, or diet pills?	<input type="checkbox"/>	<input type="checkbox"/>
47.	Do you have a history of eating disorders?	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
	FEMALES ONLY	<input type="checkbox"/>	<input type="checkbox"/>
48.	Has there been a recent change in menstrual patterns?	<input type="checkbox"/>	<input type="checkbox"/>
49.	At what age did you experience your first menstrual period? _____		
50.	When was your most recent menstrual period? ___/___/___		
51.	How much time do you usually have from the start of one period to the start of another? _____		
52.	How many periods have you had in the last year? _____		
53.	What was the longest time between one menstrual cycle and the next in the last year? _____		

Explain "Yes" Answers Here (Identify each answer with question number)

I, the undersigned, clearly understand these questions are asked in order to decide if my child can safely participate on the athletic team named above. The answers are complete and correct as of this date and he/she has my permission to participate.

Parent/Guardian Signature	Student Signature	Date
		*Must be completed & dated within 2 days of the physical
Home Phone	Work Phone	Cell Phone

For School Nurse Use:				
AB		PE		Nurse