SEQUIM SCHOOL DISTRICT NO. 323
SPORTS PREPARTICIPATION EXAM REPORT

History

Name_____ Grade_____ Sex_____ Date of Birth _____

Address_____ Telephone _____ Family Physician _____

In case of emergency, notify:
Name_____ Address_____Telephone _____

Date of last tetanus booster_____ Date of last examination by a doctor_____

The following questions are to be answered by either yes or no. Please check the appropriate space.

	Yes	No
Have you been under a doctor's care in the past 12 months?	( )	( )
Have you been in the hospital in the past 12 months?	( )	( )
Have you ever had any type of surgery?	( )	( )
Do you want to talk to a doctor about a health problem or an injury?	( )	( )
Has anyone in your immediate family ever had:		
Diabetes (high sugar in blood)?	( )	( )
Allergies (hay fever or asthma)?	( )	( )
Migraine headaches?	( )	( )
Heart trouble?	( )	( )
High blood pressure?	( )	( )
Has anyone in your family, under age 50, died suddenly?	( )	( )
Have you had or do you now have:		
Brain concussion (head injury)?	( )	( )
Tendency to lose consciousness (faint)?	( )	( )
Skull fracture?	( )	( )
Convulsions or epilepsy?	( )	( )
Neck injury?	( )	( )
Have you had or do you now have:		
Very bad (impaired) vision in one eye?	( )	( )
Temporary loss of vision?	( )	( )
To wear glasses or contact lenses?	( )	( )
Have you had or do you now have:		
Hearing loss?	( )	( )
Perforated eardrum?	( )	( )
Discharge from ear(s (recurrent infections)?	( )	( )
Sinus infections?	( )	( )
Broken nose?	( )	( )
Dental plate (dentures)?	( )	( )
Orthodontia (teeth straightened)?	( )	( )
Have you had or do you now have:		
Hernia?	( )	( )
Kidney problems?	( )	( )
Loss of function/absence of testicles (boys)?	( )	( )
Menstrual problems (girls)?	( )	( )
Age at onset of menstruation_____		
Have you had or do you now have:		
Bone fracture?	( )	( )
Joint dislocation?	( )	( )
Foot problems?	( )	( )
To wear a cast?	( )	( )

	Yes	No
Have you had or do you now have:		
Back injury or frequent backaches?	( )	( )
Knee injury (sprain) or recurrent pain?	( )	( )
Ankle injury (sprain) or recurrent pain?	( )	( )
Other joint problems (e.g., swelling, pain, decreased range of motion)?	( )	( )
Bone infection?	( )	( )
Have you had or do you now have:		
Diabetes (high sugar in blood or urine)?	( )	( )
Tendency to bleed or bruise easily?	( )	( )
Anemia ("tired" blood)?	( )	( )
Weight problem (under or overweight)?	( )	( )
Have you had or do you now have:		
Asthma (wheezing)?	( )	( )
Hay fever?	( )	( )
Hives or rash?	( )	( )
Bee-sting reactions (allergy)?	( )	( )
Reaction to medicine (allergy)?	( )	( )
Do you:		
Smoke?	( )	( )
Take any medicine regularly?	( )	( )
If YES, name of medication_____		
Take medicine for emergency use?	( )	( )
If YES, name of medication_____		
Have you had or do you now have:		
Heart trouble or murmur?	( )	( )
High blood pressure?	( )	( )
Persistent cough?	( )	( )
Chest pain with exercise?	( )	( )
Dizziness or faintness with exercise?	( )	( )
Have you had or do you now have:		
Recurrent rash?	( )	( )
Fungus infection?	( )	( )
Athlete's foot?	( )	( )
Recurrent boils (skin infection)?	( )	( )
Do you wish to discuss an emotional problem with the doctor?	( )	( )
Have you ever been told to give up sports because of a health problem?	( )	( )
If you have answered yes to any of the above questions, please explain below:		

_____

_____

I certify that the above information is correct, and give permission for my child to participate in interscholastic sports.

Parent/Guardian Signature_____ Date_____

Please be advised that the pre-participation screening physical examination in no way constitutes a complete physical examination.

PHYSICAL EXAMINATION

1. Height_____ Weight _____

2. Blood Pressure (sitting) _____

3. Vision: Left 20/_____ Right 20/ _____

	Check if within normal limits
4. Skin	( )
5. Mouth	( )
6. Eyes	( )
7. Ears	( )
8. Neck	( )
9. Lymphatics	( )
10. Respiratory	( )
11. Cardiovascular	( )
Heart	( )
Pulses	( )
12. Abdomen	( )
13. Genitalia	( )
14. Extremeties	( )
15. Neurologic	( )
Reflexes	( )
16. Orthopedic	( )
Cervical spine/back	( )
Arm/elbow/wrist/hand	( )
Knees	( )
Ankles	( )

PHYSICIAN'S STATEMENT OF HEALTH

Those licensed to perform physical examinations include a Medical Doctor (MD), Doctor of Osteopathy (DO), Advanced Registered Nurse Practitioner (ARNP), Physician's Assistant (PA), and Naturopathic Physician.

I certify that I have examined _____and have found no gross evidence of any abnormality that will interfere with his or her participation.

_____ _____,MD, DO, ARNP, or PA

Date Signature

_____

Name of Physician (Please Print)

_____

Name of Clinic

_____

Telephone Number