

Kennewick School District 17 PHYSICAL EVALUATION

Section A:	To Be	Completed	By Parent
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Section A: To Be Comple	☐ Male	☐ Female		
Student Legal Name			_	
Address_City	Zip	Phone		
Grade in the Fall	School in the Fall			
Activity: Fall	Winter	Spring		

Explain all "Yes" answers with dates and details in the area following the question.

Yes	No							
		Have you had any illness/injury recently, or do you have an illness/injury now? Explain						
		Have you had a medical problem, illness or injury since your last exam?						
		Do you have any chronic or recurrent illness? List						
		Have you ever hand any illness lasting more than a week? List						
		Have you ever been hospitalized overnight?						
		Have you ever had surgery other than a tonsillectomy? List						
		Have you ever had any injuries requiring treatment by a physician? List						
		Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc)? List						
		Are you presently taking ANY medications (including birth control pill, vitamin, aspirin, etc)? List						
		Do you have ANY allergies (medicine, bees, foods, etc)? List						
		Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?						
		Do you tire more easily or quickly than your friends during exercise?						
		Have you ever had any problem with your blood pressure or your heart?						
		Have any of your 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)? List						
		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"? Date & details						
		Have you ever had a neck or head injury? Date and severity						
		Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems?						
		Have you had asthma, trouble breathing, or cough during or after exercise?						
		Do you wear glasses or contacts or protective eye wear?						
		Have you had any problems with your eyes or vision?						
		Do you wear any dental appliance such as braces, bridge, plate, retainer?						
		Have you ever had a knee injury?						
		Have you ever had an ankle injury?						

Have you ever in	jured any other joint (s	shoulder, wrist, fing	ers, etc)?						
Have you ever ha	Have you ever had a broken bone (fracture)?								
Have you ever ha	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 than five (5) years since your last tetanus booster shot?								
Must you use sp									
Has it been more									
Are you worried	Are you worried about your weight?								
Females: Have ye	Females: Have you any menstrual problems?								
Have you any me	edical concerns about p	participating in your	activity?						
I hereby state that, to the best Student Signature									
Parent/Guardian Signature_				Date					
tion B: To Be Comple	ted By Physician	l 							
AgeHeight	Weight	BP	Pulse	Visual Acuity L 2	0/ R20/_				
	N	ormal	Abnor	mal Findings	Initial				
Head									
Eyes, ENT									
Гееth									
Chest									
Lungs									
Heart									
Abdomen									
Genitalia									
Neurologic									
Skin									
Physical Maturity									
Spine, Back									
Shoulders, Upper Extremities									
Lower Extremities									
ssessment:	limitations, restrictions in	box below)							
Participation contraindicated (li	ist reasons in box below)								