

PRE-PARTICIPATION SPORTS PHYSICAL EVALUATION

WIAA 18.13.4 The physical examination dated June 1, 2004 or later shall be valid for twenty-four (24) consecutive months to the date unless otherwise limited by local school district policy. All physical examinations conducted prior to June 1, 2004 would be valid for thirteen (13) months.

Section A: To be completed by Parent

Name _____ Male Female
 Address _____ City _____ Zip _____
 Phone _____ Date of Birth _____ Your age today _____
 Grade in the Fall _____ School in the Fall _____
 Activity Fall _____ Winter _____ Spring _____

ATHLETICS INSURANCE INFORMATION

While I expect school authorities to exert reasonable precaution to avoid injury, I understand that they assume no financial or moral obligation for accidents. I understand that my student cannot participate in boys/girls athletics unless he/she is covered by insurance with the minimum provisions. I accept full responsibility for the cost of treatment for any injury which he/she may suffer while participating in the program.

INSURANCE WAIVER

I have insurance coverage with _____ Company that provides adequate accident coverage and will keep it in force throughout the sports year.

SCHOOL INSURANCE

I do not have a family insurance policy. However, I purchased school insurance for the above named student on _____ and paid a premium of \$ _____.

Do you have a personal physician? No Yes Physician's Name _____

Explain "Yes" answers below:

	Yes	No
1. Have you ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you presently taking any medications or pills?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies (medicine, bees or other stinging insects)?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever been dizzy during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had chest pain during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you tire more quickly than your friends during exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had high blood pressure?.....	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever been told that you have a heart murmur?.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had racing of your heart or skipped heartbeats?.....	<input type="checkbox"/>	<input type="checkbox"/>
12. Has anyone in your family died of heart problems or a sudden death before age 50?.....	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you have any skin problems (itching, rashes, acne)?.....	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever had a head injury?.....	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever been knocked out or unconscious?.....	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had a seizure?.....	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever had a stinger, burner or pinched nerve?.....	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you ever had heat or muscle cramps?.....	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you ever been dizzy or passed out in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
20. Do you have trouble breathing or do you cough during or after activity?.....	<input type="checkbox"/>	<input type="checkbox"/>
21. Do you use any special equipment (pads, braces neck rolls, mouth guard, eye guards, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you had any problems with your eyes or vision?.....	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you wear glasses or contacts or protective eye wear?.....	<input type="checkbox"/>	<input type="checkbox"/>

24. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?.....
- Head Shoulder Thigh Neck Elbow Knee Chest Foot
- Forearm Shin/calf Back Wrist Ankle Hip Hand
25. Have you had any other medical problems (infections mononucleosis, diabetes, etc.)?.....
26. Have you had a medical problem or injury since your last evaluation?.....
27. When was your last tetanus shot?.....
28. When was your last measles immunization?.....
29. When was your first menstrual period?.....
30. When was your last menstrual period?.....
31. What was the longest time between your periods last year?.....

Explain "Yes" answers: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Student Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Section B: To be completed by Physician

PHYSICAL EXAMINATION						
	Complete	Limited	Height	Weight	BP /	Pulse
					Normal	Abnormal Findings
			Cardiopulmonary			
			Pulses			
			Heart			
			Lungs			
			Skin			
			Abdominal			
			Musculoskeletal			
			Neck/Spine			
			Upper Extremities			
			Lower Extremities			

CLEARANCE

- A. Cleared
- B. Not cleared for: Collision Contact Non-contact Strenuous
- Moderately strenuous Non-strenuous

Due to _____

Recommendation: _____

Name of Physician _____ Date _____

Signature of Physician _____