

## HIGH SCHOOL ENTRANCE AND/OR SPORTS PHYSICAL

Date of physical: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Father's Name \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ City/State: \_\_\_\_\_

### IMMUNIZATION RECORD

(Fill in the month, day and year for each – Schools must have complete record on file.)

DPT/DT	ORAL POLIO	MEASLES	MMR
1. _____	1. _____	1. _____	1. _____
2. _____	2. _____	2. _____	2. _____
3. _____	3. _____		
_____	_____		
_____	_____	RUBELLA	
_____	_____	(3 day or German)	MUMPS shot
_____	_____	_____	_____

HEPATITIS B: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

### MEDICAL HISTORY

Please answer the following questions by circling yes or no. If you answer yes, please explain at the bottom of the page.

- |                                                                                                                                   |     |    |
|-----------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1. Have you ever had a serious medical problem requiring surgery, hospitalization, or prolonged treatment by a doctor?            | Yes | No |
| 2. Do you take any medication of any type?                                                                                        | Yes | No |
| 3. Have you ever had a severe allergic reaction to anything?                                                                      | Yes | No |
| 4. Have you had allergic problems such as hay fever, asthma or eczema?                                                            | Yes | No |
| 5. Do you have difficult breathing or wheezing during or shortly after exercise?                                                  | Yes | No |
| 6. Have you ever had a heart murmur, racing heart or irregular heart beat?                                                        | Yes | No |
| 7. Have you ever been dizzy or passed out during exercise?                                                                        | Yes | No |
| 8. Has any family member ever had a heart attack or died suddenly before age 50?                                                  | Yes | No |
| 9. Do you have chest pain or tire more easily than others your age when exercising?                                               | Yes | No |
| 10. Have you ever suffered heat related problems such as heat cramps, severe headache, dizziness, or passing out?                 | Yes | No |
| 11. Have you ever had a significant injury such as sprain, fracture, or dislocation of a bone or joint?                           | Yes | No |
| 12. Have you ever had a concussion or been knocked unconscious?                                                                   | Yes | No |
| 13. Have you ever had a seizure?                                                                                                  | Yes | No |
| 14. Have you ever had burning pain, numbness or tingling in your arms or legs associated with any athletic or physical activity?  | Yes | No |
| 15. Is there any other medical or family history that might be important?                                                         | Yes | No |
| 16. Have you ever been taken out of or kept from participating in a sports activity or practice for an injury or physical reason? | Yes | No |
| 17. Have you ever required taping, padding or bracing before events or practice?                                                  | Yes | No |
| 18. Do you have damage or absence of one of any paired organs (i.e. kidney, testicle, ovary, eye, etc..?)                         | Yes | No |
| 19. Do you have any skin problems (rash, itching)?                                                                                | Yes | No |
| 20. In the last year, how much weight have you gained or lost?                                                                    | Yes | No |
| 21. What is the date of your last MMR? _____                                                                                      |     |    |
| 22. What is the date of your last tetanus booster? _____                                                                          |     |    |

For females only:

- |                                                                                        |     |    |
|----------------------------------------------------------------------------------------|-----|----|
| 23. What is the date of your last menstrual period? _____                              |     |    |
| 24. In the last year have you gone for three months or more without a menstrual cycle? | Yes | No |

**Physical Exam**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ (>140/85)? \_\_\_\_\_ Pulse: \_\_\_\_\_

Vision: R corrected \_\_\_\_\_ R uncorrected \_\_\_\_\_  
L corrected \_\_\_\_\_ L uncorrected \_\_\_\_\_

Glasses/Contacts/None Pupils equal: Yes No

General Observation: \_\_\_\_\_

HEENT: \_\_\_\_\_

Neck: ROM \_\_\_\_\_ palpation \_\_\_\_\_ tenderness \_\_\_\_\_

Chest: Auscultation \_\_\_\_\_ Wheezing \_\_\_\_\_ Rales \_\_\_\_\_

CV: Heart Murmurs \_\_\_\_\_ Increased with valsalva? Yes No N/A

Grade III or IV murmur? Yes No N/A Diastolic Murmur? Yes No

Rhythm \_\_\_\_\_ Click? Yes No Rub? Yes No

Pulses: Carotid \_\_\_\_\_ Radial \_\_\_\_\_ Dorsalis Pedis \_\_\_\_\_

Edema? Yes No Cyanosis? Yes No

Abdomen:

Enlarged liver? \_\_\_\_\_ Enlarged spleen? \_\_\_\_\_

Hernia? \_\_\_\_\_ Scars? \_\_\_\_\_

GU: Male \_\_\_\_\_ Testicles: R \_\_\_\_\_ L \_\_\_\_\_

Female \_\_\_\_\_

Inguinal Hernia? Yes No

Skin: General \_\_\_\_\_ Rashes \_\_\_\_\_

Impetigo \_\_\_\_\_ Herpes \_\_\_\_\_

MS: Shoulder \_\_\_\_\_

Elbow \_\_\_\_\_

Wrist/Hand \_\_\_\_\_

Hip \_\_\_\_\_

Back \_\_\_\_\_ Scoliosis? Yes No

Knee \_\_\_\_\_

Ankle \_\_\_\_\_

Feet \_\_\_\_\_

Marfan? >2 (tall \_\_\_\_\_ striae \_\_\_\_\_ hyperextensibility \_\_\_\_\_  
upper to lower body ratio <0.9 \_\_\_\_\_ lens dislocation \_\_\_\_\_)

Problems:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**The above named student has been cleared for participation in the following sports:**

- \_\_\_\_\_ Contact collision (football, soccer, wrestling, etc.)
- \_\_\_\_\_ Limited contact/impact (baseball, basketball, volleyball, etc.)
- \_\_\_\_\_ Noncontact strenuous (track, field, running, tennis, etc.)
- \_\_\_\_\_ Noncontact moderately strenuous (badminton, table tennis, etc.)
- \_\_\_\_\_ Noncontact, nonstrenuous (golf, archery, etc.)

**Additional evaluation suggested? Yes \_\_\_\_\_ No \_\_\_\_\_**

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_

Nurse Practitioner signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Physician's signature must appear also if examined by an Advanced Nurse Practitioner in written collaborative practice with physician.)