PARENT / GUARDIAN MUST COMPLETE THIS FORM

Walla Walla Public Schools STUDENT ATHLETE HEALTH HISTORY

Last First M/ D Number School Grade Grade Address Telephone Family Physician To The Parent: Please complete the Health History prior to the physical examination. Your signature is required. Yes No 1. Any chronic or recurrent lilnesses? 2. Any inness leating more than a week? 3. Any surpery other than tonsillectomy? 4. Any surpery other than tonsillectomy? 5. Any liquites requiring treatment by a physician? 6. Any surpery other than tonsillectoms? 7. Any liquites requiring treatment by a physician? 8. Any our presently taking ANY medications? 9. Any dizziness, fainting, convulsions, or frequent headachea? 9. Have you ever faessed out or been 'knocked out'? 10. Wear any dental appliance such as braces, bridge, or plate? 11. Any knee liquiny? 12. Any knee surpery? 13. Any knee surpery? 14. Any knee surpery? 15. Any knee surpery? 16. Any which primate or disclosations (shoulder, wrist, finger, etc.)? 18. Any brace bones? 19. Any organ missing other than tonsils (appendix, eye, kidney, testicles)? 20. Any hade injuny? 21. Any organ missing other than tonsils (appendix, eye, kidney, testicles)? 22. Any menstruel problems? 23. On your law to stop while running twice around a 1x-mile track? 24. Any menstruel problems? 25. On your law to stop while running twice around a 1x-mile track? 26. Any menstruel problems? 27. Any menstruel problems? 28. On your law to stop while running twice around a 1x-mile track? 29. Any menstruel problems? 20. Any menstruel problems? 21. Any menstruel problems? 22. Any menstruel problems? 23. On your law to stop while running twice around a 1x-mile track? 24. Have any close relatives of yours had a "heart attack" or "neart problem" under age 50? 20. Parkentral PERMISSION: I give permission for the above-named child to participate in the sport(s) approved by the Examinar under the auspicee of the Weils Walle Public Schools, and authorize the coach or other responsible official to obtain emergency medical care for my child should such become necessary during participation and I am not i	Name	t First	MI	Birth Date	Sex M F							
Address					Cundo							
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Yes No	· • · · · · · · · · · · · · · · · · · ·											
1. Any chronic or recurrent illnesses? 2. Any liness lasting more than a week? 3. Any hospitalization? 4. Any surgery other than tonsillectomy? 5. Any injuries requiring treatment by a physician? 6. Any surgery other than tonsillectomy? 7. Any juries requiring treatment by a physician? 8. Are you presently taking ANY medications? 9. Any dizziness, fainting, convulsions, or frequent headaches? 9. Any dear any dental appliance such as braces, bridge, or plate? 9. Any fainting any dental appliance such as braces, bridge, or plate? 9. Any fainting any dental appliance such as braces, bridge, or plate? 9. Any fainting any dental appliance such as braces, bridge, or plate? 9. Any fainting any dental appliance such as braces, bridge, or plate? 9. Any fainting any dental appliance such as braces, bridge, or plate? 9. Any fainting any dental appliance such as braces, bridge, or plate? 9. Any fainting any		A.L.		If y	ou answered YES, please explain:							
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17. Any other joint sprains or dislocations (shoulder, wrist, finger, etc.)? 18. Any broken bones? 19. Any organ missing other than tonsils (appendix, eye, kidney, testicles)? 20. Any heat exhaustion or heat stroke? 21. Any reasons why this applicant should not participate in sports? 22. Any menstrual problems? 23. Do you have to stop while running twice around a %-mile track? 24. Have any close relatives of yours had a "heart attack" or "heart problem" under age 50? Date of most recent Tetanus Booster (Tetanus Booster required every 10 years). If due please obtain with athletic physical. Comments: PARENTAL PERMISSION: I give permission for the above-named child to participate in the sport(s) approved by the Examiner under the auspices of the Walla Walla Public Schools, and authorize the coach or other responsible official to obtain emergency medical care for my child should such become necessary during participation and I am not immediately available.	16. 🔲											
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PHYSICIAN MUST COMPLETE THIS FORM

Walla Walla Public Schools STUDENT ATHLETE PHYSICAL EXAMINATION

NAM						GRADE	7 8	9	10	11	12
		ast F	First		MI	,	Optional				
Age:_		Pulse:		U	rinalysis:		~orioµg				
Height	t:	Blood Pressure:		В	ody Fat %						
Weigh	nt:	Visual Acuity: Left 20,			CT:						
		Right 20/			ST VO2 Max:						
					OT VOZ MAX.	ı					=
				A	udiometry:						•
Norma	 al		Abnormal	<u> </u>							l
	1.	Head				-					
	2.	Eyes (pupils), ENT									
	3.	Teeth									
	4.	Chest									
	5.	Lungs				······································					
	6.	Heart									
	7.	Abdomen									
	8.	Genitalia						1		•	
	9.	Neurologic									
	10.	Skin									
	11.	Physical Maturity				•					
	12.	Spine, Back			<u> </u>						
	13.	Shoulders, Upper extremities				·					
	14.	Lower extremities									
Assess	sment:	☐ Full participation									
		Limited participation (desc	ribe limitation	is, restrictions)	:						
		☐ Participation contraindicate	ed (list reasor	ns):							
											
Recom		ons (equipment, taping, rehabilita									
									 .		
DATE:		·	EXAMIN	IER'S SIGNAT	URE:						
		PHONE: ()		EXAMINER'S SIGNATURE:PRINT EXAMINER'S NAME:							