

**PARENT / GUARDIAN
MUST COMPLETE THIS
FORM**

**Walla Walla Public Schools
STUDENT ATHLETE HEALTH HISTORY**

Name _____ Birth Date _____ Sex M F
Last First MI

ID Number _____ School _____ Grade _____

Address _____ Telephone _____

Parent / Guardian _____ Family Physician _____

To The Parent:
Please complete the Health History prior to the physical examination. Your signature is required.

If you answered YES, please explain:

- | Yes | No | |
|------------------------------|--------------------------|---|
| 1. <input type="checkbox"/> | <input type="checkbox"/> | Any chronic or recurrent illnesses? _____ |
| 2. <input type="checkbox"/> | <input type="checkbox"/> | Any illness lasting more than a week? _____ |
| 3. <input type="checkbox"/> | <input type="checkbox"/> | Any hospitalization? _____ |
| 4. <input type="checkbox"/> | <input type="checkbox"/> | Any surgery other than tonsillectomy? _____ |
| 5. <input type="checkbox"/> | <input type="checkbox"/> | Any injuries requiring treatment by a physician? _____ |
| 6. <input type="checkbox"/> | <input type="checkbox"/> | Are you presently taking ANY medications? _____ |
| 7. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any problem with your blood pressure or your heart? _____ |
| 8. <input type="checkbox"/> | <input type="checkbox"/> | Any dizziness, fainting, convulsions, or frequent headaches? _____ |
| 9. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever "passed out" or been "knocked out"? _____ |
| 10. <input type="checkbox"/> | <input type="checkbox"/> | Wear eyeglasses or contact lenses? _____ |
| 11. <input type="checkbox"/> | <input type="checkbox"/> | Wear any dental appliance such as braces, bridge, or plate? _____ |
| 12. <input type="checkbox"/> | <input type="checkbox"/> | Allergic to ANY medication (asprin, penicillin, etc.)? _____ |
| 13. <input type="checkbox"/> | <input type="checkbox"/> | Any knee injury? _____ |
| 14. <input type="checkbox"/> | <input type="checkbox"/> | Any knee surgery? _____ |
| 15. <input type="checkbox"/> | <input type="checkbox"/> | Any ankle injury? _____ |
| 16. <input type="checkbox"/> | <input type="checkbox"/> | Any history of neck injury? _____ |
| 17. <input type="checkbox"/> | <input type="checkbox"/> | Any other joint sprains or dislocations (shoulder, wrist, finger, etc.)? _____ |
| 18. <input type="checkbox"/> | <input type="checkbox"/> | Any broken bones? _____ |
| 19. <input type="checkbox"/> | <input type="checkbox"/> | Any organ missing other than tonsils (appendix, eye, kidney, testicles)? _____ |
| 20. <input type="checkbox"/> | <input type="checkbox"/> | Any heat exhaustion or heat stroke? _____ |
| 21. <input type="checkbox"/> | <input type="checkbox"/> | Any reasons why this applicant should not participate in sports? _____ |
| 22. <input type="checkbox"/> | <input type="checkbox"/> | Any menstrual problems? _____ |
| 23. <input type="checkbox"/> | <input type="checkbox"/> | Do you have to stop while running twice around a 1/4-mile track? _____ |
| 24. <input type="checkbox"/> | <input type="checkbox"/> | 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.

DATE _____ SIGNATURE: PARENT/GUARDIAN _____

PHYSICIAN MUST COMPLETE THIS FORM

Walla Walla Public Schools
STUDENT ATHLETE PHYSICAL EXAMINATION

NAME _____ GRADE 7 8 9 10 11 12
Last First MI

Age: _____ Pulse: _____
Height: _____ Blood Pressure: _____
Weight: _____ Visual Acuity: Left 20/ _____
Right 20/ _____

Optional
Urinalysis:

Body Fat %

HCT:

EST VO2 Max:

Audiometry:

Normal		Abnormal	
<input type="checkbox"/>	1. Head	<input type="checkbox"/>	_____
<input type="checkbox"/>	2. Eyes (pupils), ENT	<input type="checkbox"/>	_____
<input type="checkbox"/>	3. Teeth	<input type="checkbox"/>	_____
<input type="checkbox"/>	4. Chest	<input type="checkbox"/>	_____
<input type="checkbox"/>	5. Lungs	<input type="checkbox"/>	_____
<input type="checkbox"/>	6. Heart	<input type="checkbox"/>	_____
<input type="checkbox"/>	7. Abdomen	<input type="checkbox"/>	_____
<input type="checkbox"/>	8. Genitalia	<input type="checkbox"/>	_____
<input type="checkbox"/>	9. Neurologic	<input type="checkbox"/>	_____
<input type="checkbox"/>	10. Skin	<input type="checkbox"/>	_____
<input type="checkbox"/>	11. Physical Maturity	<input type="checkbox"/>	_____
<input type="checkbox"/>	12. Spine, Back	<input type="checkbox"/>	_____
<input type="checkbox"/>	13. Shoulders, Upper extremities	<input type="checkbox"/>	_____
<input type="checkbox"/>	14. Lower extremities	<input type="checkbox"/>	_____

Assessment: Full participation
 Limited participation (describe limitations, restrictions):

Participation contraindicated (list reasons):

Recommendations (equipment, taping, rehabilitation, etc.):

DATE: _____ EXAMINER'S SIGNATURE: _____
EXAMINER'S PHONE: () _____ PRINT EXAMINER'S NAME: _____

Physical Examinations are valid for 24 months from date of exam