WYOMING HIGH SCHOOL ACTIVITIES ASSOCIATION
SCHOOL PHYSICAL EXAMINATION
MEDICAL RECORD

PHYSICIANS STATEMENT MUST BE DATED AFTER MAY 1 TO BE VALID FOR THE UPCOMING SCHOOL YEAR

Name _____ Sex _____ Age _____ Date of Birth _____

Grade _____ School _____ Sport(s) _____

Address _____ Phone _____

Personal Physician _____

In case of emergency, contact

Name _____ Relationship _____ Phone (H) _____ (W) _____

Explain "Yes" answers below. Circle questions you don't know the answers to.

	Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	[ ]	[ ]
2. Have you ever been hospitalized overnight?	[ ]	[ ]
3. Are you currently taking any prescription of nonprescription (over-the-counter) medications or pills or using an inhaler?	[ ]	[ ]
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	[ ]	[ ]
5. Have you ever passed out during or after exercise?	[ ]	[ ]
Have you ever been dizzy during or after exercise?	[ ]	[ ]
Have you ever had chest pain during or after exercise?	[ ]	[ ]
Do you get tired more quickly than your friends do during exercise?	[ ]	[ ]
Have you ever had racing of your heart or skipped heartbeats?	[ ]	[ ]
Have you had high blood pressure or high cholesterol?	[ ]	[ ]
Have you ever been told you have a heart murmur?	[ ]	[ ]
Has any family member or relative died of heart problems or of sudden death before age 50?	[ ]	[ ]
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	[ ]	[ ]
Has a physician ever denied or restricted your participation in sports for any heart problems?	[ ]	[ ]
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	[ ]	[ ]
7. Have you ever had a head injury or concussion?	[ ]	[ ]
Have you ever been knocked out, become unconscious, or lost your memory?	[ ]	[ ]
Have you ever had a seizure?	[ ]	[ ]
Do you have frequent or severe headaches?	[ ]	[ ]
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	[ ]	[ ]
Have you ever had a stinger, burner, or pinched nerve?	[ ]	[ ]
8. Have you ever become ill from exercising in the heat?	[ ]	[ ]
9. Do you cough, wheeze, or have trouble breathing during or after activity?	[ ]	[ ]
Do you have asthma?	[ ]	[ ]
Do you have seasonal allergies that require medical treatment?	[ ]	[ ]

	Yes	No
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	[ ]	[ ]
11. Have you had any problems with your eyes or vision?	[ ]	[ ]
Do you wear glasses, contacts, or protective eyewear?	[ ]	[ ]
12. Have you ever had a sprain, strain, or swelling after injury?	[ ]	[ ]
Have you broken or fractured any bones or dislocated any joints?	[ ]	[ ]
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	[ ]	[ ]

If yes, check appropriate box and explain below

[ ] Head	[ ] Elbow	[ ] Hip
[ ] Neck	[ ] Forearm	[ ] Thigh
[ ] Back	[ ] Wrist	[ ] Knee
[ ] Chest	[ ] Hand	[ ] Shin/calf
[ ] Shoulder	[ ] Finger	[ ] Ankle
[ ] Upper Arm		[ ] Foot

	Yes	No
13. Do you want to weigh more or less than you do now?	[ ]	[ ]
Do you lose weight regularly to meet weight requirements for your sport?	[ ]	[ ]
14. Do you feel stressed out?	[ ]	[ ]

15. Record the dates of your most recent immunizations (shots) for:

Tetanus _____ Measles _____

Hepatitis B _____ Chickenpox _____

FEMALES ONLY

16. When was your first menstrual period? _____

When was your most recent menstrual period? _____

How much time do you usually have from the start of one period to the start of another? _____

How many periods have you had in the last year? _____

What was the longest time between periods in the last year?

Explain "Yes" answers here: _____

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

Signature of athlete _____ Signature of parent/guardian _____ Date _____

PARENT/GUARDIAN CONSENT FOR EMERGENCY MEDICAL ASSISTANCE

I hereby authorize _____ School District and its faculty members in charge of my child named below to obtain all necessary medical care for my child in the event that I cannot be reached to authorize it myself. I hereby authorize any licensed physician and/or medical personnel to render necessary medical treatment to my child.

Student's Name _____ Work Phone Number; Father _____
Address _____ Mother _____
_____ Home Phone Number _____

INSURANCE INFORMATION: Company _____ Policy # _____
Insured Person _____
Policy Holder's Social Security Number _____

Signature acknowledges that we have read and understand the above warning and we give consent for emergency assistance that might be needed.

Date _____ Signature of Parent/Guardian _____

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PHYSICIANS STATEMENT MUST BE DATED AFTER MAY 1 TO BE VALID FOR THE UPCOMING SCHOOL YEAR

DATE OF EXAM _____

Name _____ Date of Birth _____

Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP ___/___ (___/___, ___/___)

Vision R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS
MEDICAL		
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand		
Hip/thigh		
Knee		
Leg/ankle		
Foot		

*Normal indicated by check or N

[ ] **Cleared**

***[ ] Cleared after completing evaluation/rehabilitation for:** _____

_____

_____

_____

_____

***[ ] Not cleared for:** _____ **Reason:** _____

Recommendations: _____

_____

_____

_____

***IF THESE BOXES ARE CHECKED, A COPY OF THIS FORM NEEDS TO BE SENT TO THE APPROPRIATE SCHOOL DISTRICT.**

Name of physician (print/type) _____ **Date** _____

Address _____ **Phone** _____

Signature of physician_____, **MD or DO**

STUDENT/PARENT/GUARDIAN INFORMED CONSENT

Participation in all activities requires the acceptance of risk of possible serious injury. The risk can be minimized by following your coaches' rules and procedures, by familiarizing yourself with the rules of the activity, and by following the specific rules issued by manufacturers for the safe use of your activity equipment. The risk is always there, but you can help minimize it by making safety a shared responsibility. When you make the decision to participate in an activity, you are assuming the shared responsibility of following the activities rules, the coaches' rules, and the equipment manufacturer's rules. You, as a participant, can help make the activity safer by not intentionally using techniques which are illegal and which can cause serious injury.

Your signature below indicates that you have been informed about the importance of following rules in activities participation; and you realize that there is a risk of being injured that is inherent in all activities. You realize that the risk of injury may be severe, including the risk of fractures, brain injuries, paralysis or even death.

Activity programs specifically excluded: _____

Date _____ Signature of Student _____

Signature of Parent _____

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

Signature of athlete _____ Signature of parent/guardian _____ Date _____

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