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.	☐	☐	Any chronic or recurrent illnesses?	_____
2.	☐	☐	Any illness lasting more than a week?	_____
3.	☐	☐	Any hospitalization?	_____
4.	☐	☐	Any surgery other than tonsillectomy?	_____
5.	☐	☐	Any injuries requiring treatment by a physician?	_____
6.	☐	☐	Are you presently taking ANY medications?	_____
7.	☐	☐	Have you ever had any problem with your blood pressure or your heart?	_____
8.	☐	☐	Any dizziness, fainting, convulsions, or frequent headaches?	_____
9.	☐	☐	Have you ever “passed out” or been “knocked out”?	_____
10.	☐	☐	Wear eyeglasses or contact lenses?	_____
11.	☐	☐	Wear any dental appliance such as braces, bridge, or plate?	_____
12.	☐	☐	Allergic to ANY medication (asprin, penicillin, etc.)?	_____
13.	☐	☐	Any knee injury?	_____
14.	☐	☐	Any knee surgery?	_____
15.	☐	☐	Any ankle injury?	_____
16.	☐	☐	Any history of neck injury?	_____
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 ¼-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.

DATE _____ SIGNATURE: PARENT/GUARDIAN _____

PHYSICIAN MUST COMPLETE THIS FORM

Walla Walla Public Schools

STUDENT ATHLETE PHYSICAL EXAMINATION

NAME _____ **GRADE** 6 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	
☐	1.	Head	☐	
☐	2.	Eyes (pupils), ENT	☐	
☐	3.	Teeth	☐	
☐	4.	Chest	☐	
☐	5.	Lungs	☐	
☐	6.	Heart	☐	
☐	7.	Abdomen	☐	
☐	8.	Genitalia	☐	
☐	9.	Neurologic	☐	
☐	10.	Skin	☐	
☐	11.	Physical Maturity	☐	
☐	12.	Spine, Back	☐	
☐	13.	Shoulders, Upper extremities	☐	
☐	14.	Lower extremities	☐	

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