

# WHATCOM COUNTY SPORTS PHYSICAL EXAM

(Required prior to participation in Middle & High Schools – PARENTS MUST REVIEW & SIGN)

Pre-Participation

Returning

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ School \_\_\_\_\_ Exam Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

Parent's Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Sport (s) \_\_\_\_\_

In case of emergency contact: Name \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

## MEDICAL HISTORY

Yes/No

(to be completed by student & parents/guardians)

- Y N** 1. Have you had any illness/injury recently or now?  
**Y N** 2. Have you had a medical problem, illness or injury since your last exam?  
**Y N** 3. Do you have any chronic or recurrent illness?  
**Y N** 4. Have you ever had an illness lasting more than a week?  
**Y N** 5. Have you ever been hospitalized overnight?  
**Y N** 6. Have you had any surgery?  
**Y N** 7. Have you ever had any injuries requiring treatment by a physician?  
**Y N** 8. Do you have any organs missing? (*appendix, eye, kidney, testicle, etc.*)  
**Y N** 9. Are you presently taking **any** medications? (*including vitamins, aspirin*)  
**Y N** 10. Do you have **any** allergies? (*medicine, bees, foods*)  
**Y N** 11. Have you ever had chest pain, dizziness, fainting, or passing out during or after exercise?  
**Y N** 12. Do you tire more easily or quickly than your friends during exercise?  
**Y N** 13. Have you ever had any problem with your blood pressure or your heart?  
**Y N** 14. Have any close relatives had heart problems, heart attacks, or sudden death **before** they were age 50?  
**Y N** 15. Do you have any skin problems? (*acne, itching, rashes, etc.*)  
**Y N** 16. Have you ever had fainting, convulsions, seizures or severe dizziness?  
**Y N** 17. Do you have frequent severe headaches?  
**Y N** 18. Have you ever had a "stinger" or "burner" or "pinched nerve?"  
**Y N** 19. Have you ever been "knocked out" or "passed out?"  
**Y N** 20. Have you ever had a neck or head injury?  
**Y N** 21. Have you ever had heat exhaustion, heat stroke, heat cramps, or similar heat-related problems?  
**Y N** 22. Do you have asthma, trouble breathing, or cough during or after exercise?  
**Y N** 23. Do you wear eyeglasses, contact lenses, or protective eyewear?  
**Y N** 24. Have you had any problem with your eyes or vision?  
**Y N** 25. Do you wear any dental appliance? (*braces, bridge, plate, retainer*)  
**Y N** 26. Have you ever had a knee or ankle injury?  
**Y N** 27. Have you ever injured any other joint? (*shoulder, wrist, fingers, etc.*)  
**Y N** 28. Have you ever had a broken bone? (*fracture*)  
**Y N** 29. Have you ever had a cast, splint, or had to use crutches?  
**Y N** 30. Must you use special equipment for competition? (*braces, etc.*)  
**Y N** 31. Has it been more than eight years since your last tetanus booster shot?  
**Y N** 32. Are you worried about your weight?  
**Y N** 33. Have you any medical concerns about participating in your sport?  
**Y N** 34. Are you taking any pills or drugs to increase your strength or performance?  
**Y N** 35. **FEMALES:** Have you any menstrual problems?



**I attest, by my signature below, that to the best of my knowledge, my answers to the above questions are complete and correct.**

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature of Student \_\_\_\_\_ Date \_\_\_\_\_

## PHYSICAL

(to be completed by doctor)

Age \_\_\_\_\_ Height \_\_\_\_\_

Weight \_\_\_\_\_ BP \_\_\_\_\_

Pulse \_\_\_\_\_

Vision R \_\_\_\_ / \_\_\_\_ L \_\_\_\_ / \_\_\_\_

## MEDICAL

Normal/Abnormal

Findings

**N A** Appearance \_\_\_\_\_

**N A** Eyes \_\_\_\_\_

**N A** Ears \_\_\_\_\_

**N A** Nose \_\_\_\_\_

**N A** Throat \_\_\_\_\_

**N A** Heart \_\_\_\_\_

**N A** Lymph Nodes \_\_\_\_\_

**N A** Pulses \_\_\_\_\_

**N A** Lungs \_\_\_\_\_

**N A** Abdomen \_\_\_\_\_

**N A** Genitalia (*males only*) \_\_\_\_\_

**N A** Skin \_\_\_\_\_

## MUSCULOSKELETAL

**N A** Neck \_\_\_\_\_

**N A** Back \_\_\_\_\_

**N A** Shoulder/Arm \_\_\_\_\_

**N A** Elbow/Forearm \_\_\_\_\_

**N A** Wrist/Hand \_\_\_\_\_

**N A** Hip/Thigh \_\_\_\_\_

**N A** Knee \_\_\_\_\_

**N A** Leg/Ankle \_\_\_\_\_

**N A** Foot \_\_\_\_\_

## ASSESSMENT

Full Participation  Limited Participation

Describe limitations, restrictions \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Participation contraindicated (*list reasons*) \_\_\_\_\_

\_\_\_\_\_

Recommendations (*equipment, taping, rehabilitation,*

*referral*) \_\_\_\_\_

\_\_\_\_\_



Examiner's Name \_\_\_\_\_

Signature \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_\_