



Kennewick School District 17 PHYSICAL EVALUATION

Section A: To Be Completed By Parent

Male Female

Student Legal Name _____

Address City _____ Zip _____ Phone _____

Grade in the Fall _____ School in the Fall _____

Activity: Fall _____ Winter _____ Spring _____

Explain all "Yes" answers with dates and details in the area following the question.

Yes	No	
		Have you had any illness/injury recently, or do you have an illness/injury now? Explain
		Have you had a medical problem, illness or injury since your last exam?
		Do you have any chronic or recurrent illness? List
		Have you ever had any illness lasting more than a week? List
		Have you ever been hospitalized overnight?
		Have you ever had surgery other than a tonsillectomy? List
		Have you ever had any injuries requiring treatment by a physician? List
		Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc)? List
		Are you presently taking ANY medications (including birth control pill, vitamin, aspirin, etc)? List
		Do you have ANY allergies (medicine, bees, foods, etc)? List
		Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?
		Do you tire more easily or quickly than your friends during exercise?
		Have you ever had any problem with your blood pressure or your heart?
		Have any of your close relatives had heart problems, heart attack or sudden death before they were age 50?
		Do you have any skin problems (acne, itching, rashes, etc)? List
		Have you ever had fainting, convulsions, seizures or severe dizziness?
		Do you have frequent severe headaches?
		Have you ever had a "stinger" or "burner" or pinched nerve?
		Have you ever been "knocked out" or "passed out"? Date & details
		Have you ever had a neck or head injury? Date and severity
		Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems?
		Have you had asthma, trouble breathing, or cough during or after exercise?
		Do you wear glasses or contacts or protective eye wear?
		Have you had any problems with your eyes or vision?
		Do you wear any dental appliance such as braces, bridge, plate, retainer?
		Have you ever had a knee injury?
		Have you ever had an ankle injury?

Student Name (Last, First) _____

Expiration Date _____

	Have you ever injured any other joint (shoulder, wrist, fingers, etc)?
	Have you ever had a broken bone (fracture)?
	Have you ever had a cast, splint, or had to use crutches?
	Must you use special equipment for competition (pads, braces, neck roll, etc)?
	Has it been more than five (5) years since your last tetanus booster shot?
	Are you worried about your weight?
	Females: Have you any menstrual problems?
	Have you any medical concerns about participating in your activity?

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

Student Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Section B: To Be Completed By Physician

Age _____	Height _____	Weight _____	BP _____	Pulse _____	Visual Acuity L 20/ R 20/ _
		Normal		Abnormal Findings	Initials
Head					
Eyes, ENT					
Teeth					
Chest					
Lungs					
Heart					
Abdomen					
Genitalia					
Neurologic					
Skin					
Physical Maturity					
Spine, Back					
Shoulders, Upper Extremities					
Lower Extremities					

Assessment: Full Participation

Limited Participation (describe limitations, restrictions in box below)

Participation contraindicated (list reasons in box below)

Date _____ Physician's Signature _____ Print Physician Name _