

**Physical Examination**  
(to be completed by examiner)

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

**Normal**

- 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

**Abnormal**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

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

\_\_\_\_\_

Participation Contraindicated (list reasons):

\_\_\_\_\_

Recommendations (see your healthcare provider):

\_\_\_\_\_

Follow-up With: \_\_\_\_\_

Examiner's Phone

Examiner's Printed Name

Date

Examiner's Signature

# Olympia School District

## Physical Examination Form

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Sport(s): \_\_\_\_\_

Primary Care Provider Name: \_\_\_\_\_

\_\_\_\_\_

Health Insurance (State "none" if applicable):

\_\_\_\_\_

Examination Date: \_\_\_\_\_

## Pre-participation History and Physical Examination

(to be completed by student / parent /legal guardian prior to examination)

**Examiner's Comments  
on all "YES" Answers  
(refer to question number):**

	YES	NO		
1.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any illness/injury within the past year which required you to see a healthcare provider?	
2.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any chronic or recurrent illness?	
3.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been hospitalized overnight?	
4.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any surgery?	
5.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any injuries requiring treatment by a physician?	
6.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any organs missing (spleen, eye, kidney, testicle, lung)?	
7.	<input type="checkbox"/>	<input type="checkbox"/>	Are you presently taking ANY medications (including birth control pill, vitamin, aspirin, etc.)?	
8.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have ANY allergies (medicines, bees, foods, or other factors)?	
9.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?	
10.	<input type="checkbox"/>	<input type="checkbox"/>	Do you tire more easily or quickly than your friends during exercise?	
11.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any problem with your blood pressure or your heart?	
12.	<input type="checkbox"/>	<input type="checkbox"/>	Have any close relatives had heart problems, heart attack or sudden death <b>before</b> they were age 50?	
13.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any skin problems (new or changing moles, lumps)?	
14.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had fainting, convulsions, seizures or severe dizziness?	
15.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have frequent severe headaches?	
16.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a "stinger" or "burner" or "pinched nerve"?	
17.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been "knocked out", had a concussion, or other head injury?	
18.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a neck or head injury?	
19.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had heat exhaustion or heat stroke?	
20.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had asthma, or trouble breathing, or cough during or after exercise?	
21.	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear eyeglasses, contact lenses or protective eye wear during exercise?	
22.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any problem with your eyes or vision?	
23.	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear any dental appliance such as braces, bridge, plate, retainer?	
24.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a knee injury?	
25.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an ankle injury?	
26.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever injured any other joint (shoulder, wrist, fingers, etc.) or have loose joints?	
27.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a broken bone (fracture)?	
28.	<input type="checkbox"/>	<input type="checkbox"/>	Must you use special equipment for competition (pads, braces, neck roll, etc.)?	
29.	<input type="checkbox"/>	<input type="checkbox"/>	When was your last tetanus booster shot?	
30.	<input type="checkbox"/>	<input type="checkbox"/>	FEMALES: Do you have any menstrual problems? Anemia?	
31.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any medical concerns about participating in your sport?	