This Page To Be Completed By Licensed Practitioner

Widefield School District 3
Physical Examination Form

Student Name: _____ (First Name) _____ (Last Name) **Date of Birth** _____ (mm/dd/yyyy)

Height _____ **Weight** _____ **Pulse** _____ **BP** _____ / _____ **(** _____ / _____ **,** _____ / _____ **)**

Vision **R20/** _____ **L20/** _____ **Corrected:** ☐ **Yes** ☐ **No** **Pupils: Equal** ☐ **Unequal** ☐

	Normal	Abnormal Findings	Initials
Medical			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

Medical Determination

Cleared for sports participation ☐

Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ **Reason:** _____

Recommendations: _____

Comments: _____

Name of Physician (Print/Type) _____ **Phone:** _____

Physician's Address: _____

Signature of Physician, M.D. or D.O. _____ **Date:** _____

To Be Completed by Parent, Guardian or Student

Widefield School District 3
Athletic Medical History

Student Name:			
Sex: ☐ **M** ☐ **F**	**Age:**	**Date of Birth:**	**Grade:**
Sport by Season:	**Fall:**	**Winter:**	**Spring:**
Primary Physician:		**Physician's Phone:**	
Insurance Provider:		**ID Number:**	

Please check the appropriate response to the questions below:

Have you ever passed out during or after exercise?	Yes ☐	No ☐
Have you ever been dizzy during or after exercise?	Yes ☐	No ☐
Have you ever had chest pain during or after exercise?	Yes ☐	No ☐
Do you tire more quickly than your friends during exercise?	Yes ☐	No ☐
Have you ever had high blood pressure?	Yes ☐	No ☐
Have you ever been told you have a heart murmur?	Yes ☐	No ☐
Have you ever had racing of your heart or skipped heartbeats?	Yes ☐	No ☐
Has anyone in your family died of heart problems before age 50?	Yes ☐	No ☐
Do you have a history of asthma?	Yes ☐	No ☐
Do you have trouble breathing or do you cough during or after exercise?	Yes ☐	No ☐
Have you ever had a head injury?	Yes ☐	No ☐
Have you ever been hospitalized?	Yes ☐	No ☐
Have you ever had surgery?	Yes ☐	No ☐
Are you presently taking prescribed or over the counter medications?	Yes ☐	No ☐
Do you have any allergies?	Yes ☐	No ☐
Do you have any skin problems (itching, rashes, acne, other)?	Yes ☐	No ☐
Have you ever had heat or muscle cramps?	Yes ☐	No ☐
Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guard, other)?	Yes ☐	No ☐
Do you have any problems with your eyes or vision?	Yes ☐	No ☐
Have you ever sprained/strained, dislocated, fractured, broken, or had repeated swelling to any bone or joint? If Yes, please explain:	Yes ☐	No ☐
Do you have any other medical problems (infectious mononucleosis, diabetes, etc.)? If Yes, please explain:	Yes ☐	No ☐
Do you have a history of sickle cell anemia in your family?	Yes ☐	No ☐
Have you had a medical problem or injury since your last evaluation?	Yes ☐	No ☐
Do you have any menstrual difficulties?	Yes ☐	No ☐
Date of last tetanus shot:		
Date of last measles immunization:		

Please use the space below to explain all 'yes' answers. Please use an additional sheet of paper if more space is needed.

I certify the above information is accurate and complete to the best of my knowledge.

Parent Signature (required) **Date** **Student Signature** **Date**

By signing this form, you, as the athlete, and the parent or legal guardian, indicate the understanding by participating in a physical at a district school, that there is no guarantee of confidentiality of protected health information. Signing of this form also releases medical professionals and the district of any liability as a result of unintentional disclosure of such information.