NATRONA COUNTY SCHOOL DISTRICT
SCHOOL PHYSICAL EXAM FORM

PHYSICIAN'S STATEMENT MUST BE DATED AFTER MAY 1 TO BE VALID FOR THE UPCOMING SCHOOL YEAR

RED Areas Are to Be Completed by Parent and Student Prior to Physical Examination

STUDENT INFORMATION

School: _____ Date of Exam: _____

Name: _____ Date of Birth: _____

Grade: _____ Gender: ☐ Male ☐ Female

Height: _____ **Weight:** _____ **% Body Fat (optional):** _____ **Pulse:** _____ **BP:** _____

Vision: R 20/___ L 20/___ **Corrected:** ☐ Yes ☐ No **Pupils:** Equal _____ Unequal _____

MEDICAL	NORMAL*	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitilia (males only)		
Skin		

MUSCULOSKELETAL	NORMAL *	ABNORMAL FINDINGS
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

*Normal by check (√) or No

☐ Cleared

☐ *Cleared after completing evaluation/rehabilitation for: _____

_____

_____

☐ Not cleared for : _____

Reason: _____

Recommendations: _____

_____

_____

Physician's Name (print/type): _____ Date: _____

Address: _____ Phone: _____

Signature of Physician: _____ ☐ MD ☐ DO

MEDICAL/HEALTH HISTORY

Please explain "Yes" answers on bottom of page

Y	N		
☐	☐	1.	Have you ever been hospitalized?
☐	☐	a.	Have you ever had surgery?
☐	☐	2.	Are you presently taking any medications or pills?
☐	☐	3.	Do you have any allergies (medicine, bees or other stinging insects)?
☐	☐	4.	Have you ever passed out during or after exercise?
☐	☐	a.	Have you ever been dizzy during or after exercise?
☐	☐	b.	Have you ever had chest pain during or after exercise?
☐	☐	c.	Do you tire more easily that your friends during exercise?
☐	☐	d.	Have you ever had high blood pressure?
☐	☐	e.	Have you ever been told that you have a heart murmur?
☐	☐	f.	Have you ever had racing of your heart or skipped heartbeats?
☐	☐	g.	Has anyone in your family died of heart problems or a sudden death before age 50?
☐	☐	5.	Do you have any skin problems (itching, rashes, acne)?
☐	☐	6.	Have you ever had a head injury?
☐	☐	a.	Have you ever been knocked out, unconscious, or lost your memory?
☐	☐	b.	Have you ever had a seizure?
☐	☐	c.	Have you ever had a stinger, burner, pinched nerve, or numbness in extremities?
☐	☐	7.	Have you ever had heat or muscle cramps?
☐	☐	a.	Have you ever been dizzy, passed out, or become ill due to heat?
☐	☐	8.	Do you have trouble breathing or do you cough during or after activity?
☐	☐	9.	Do you use special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?
☐	☐	10.	Have you had any problems with your eyes or vision?
☐	☐	a.	Do you wear glasses or contacts or protective eye wear?
		11.	Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?

☐ Head ☐ Elbow ☐ Shoulder ☐ Neck ☐ Thigh ☐ Knee ☐ Foot

☐ Back ☐ Chest ☐ Forearm ☐ Wrist ☐ Ankle ☐ Hand ☐ Hip ☐ Shin/Calf

Y	N		
☐	☐	12.	Have you had any other medical problems (asthma, diabetes, mononucleosis, etc.)?
☐	☐	13.	Have you had a medical problem or injury since your last evaluation?
		14.	When was your first menstrual period?
		a.	When was your last menstrual period?
		b.	What was the longest time between your periods last year? _____
Y	N		
☐	☐	15.	Has a physician ever denied or restricted your participation in sports or any physical activity?

Explain all "Yes" answers

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PLEASE TURN IN TOGETHER: 1) COMPLETED PHYSICAL 2) INSURANCE APPLICATION 3) INSURANCE PREMIUM PAYMENT TO THE SCHOOL ATHLETIC DIRECTOR OR ATHLETIC/ACTIVITIES FACILITATOR-ML AT THE SAME TIME