

**PREPARTICIPATION HISTORY AND PHYSICAL EXAMINATION**

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Exam Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

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

**HISTORY**

- |       | <b>YES</b> | <b>NO</b> |  |
|-------|------------|-----------|--|
| 1. a. | ( )        | ( )       | Have you had any illness/injury recently, or do you have an illness/injury now?                    |
| b.    | ( )        | ( )       | Have you had a medical problem, illness or injury since your last exam?                            |
| c.    | ( )        | ( )       | Do you have any chronic or recurrent illness?  |
| d.    | ( )        | ( )       | Have you ever had any illness lasting more than a week?  |
| e.    | ( )        | ( )       | Have you ever been hospitalized overnight?   |
| f.    | ( )        | ( )       | Have you had any surgery other than tonsillectomy?   |
| g.    | ( )        | ( )       | Have you ever had any injuries requiring treatment by a physician?                                 |
| h.    | ( )        | ( )       | Do you have any organ missing other than tonsils(appendix, eye, kidney, testicle,)?                |
| 2.    | ( )        | ( )       | Are you presently taking ANY medications(including birth control pill, vitamin, aspirin etc.)?     |
| 3.    | ( )        | ( )       | Do you have ANY allergies (medicines, bees, foods, or other factors)?                              |
| 4. a. | ( )        | ( )       | Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?           |
| b.    | ( )        | ( )       | Do you tire more easily or quickly than your friends during exercise?                              |
| c.    | ( )        | ( )       | Have you ever had any problem with your blood pressure or your heart?                              |
| d.    | ( )        | ( )       | Have any close relatives had heart problems, heart attack or sudden death before they were age 20. |
| 5.    | ( )        | ( )       | Do you have any skin problems (acne, itching, rashes. etc.)?                                       |
| 6. a. | ( )        | ( )       | Have you ever had fainting, convulsions, seizures or severe dizziness?                             |
| b.    | ( )        | ( )       | Do you have frequent severe headaches?   |
| c.    | ( )        | ( )       | Have you ever had a "stinger" or "burner" or "pinched nerve"?                                      |
| d.    | ( )        | ( )       | Have you ever been "knocked out" or "passed out"?  |
| e.    | ( )        | ( )       | Have you ever had a neck or head injury?   |
| 7.    | ( )        | ( )       | Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems?      |
| 8.    | ( )        | ( )       | Have you had asthma, or trouble breathing, or cough during or after exercise?                      |
| 9. a. | ( )        | ( )       | Do you wear eyeglasses, contact lenses or protective eye wear?                                     |
| b.    | ( )        | ( )       | Have you had any problem with your eyes or vision?   |
| 10.   | ( )        | ( )       | Do you wear any dental appliance such as braces, bridge, plate, retainer?                          |
| 11.a. | ( )        | ( )       | Have you ever had a knee injury?   |
| b.    | ( )        | ( )       | Have you ever had an ankle injury?   |
| c.    | ( )        | ( )       | Have you ever injured any other joint (shoulder, wrist, fingers, etc.)?                            |
| d.    | ( )        | ( )       | Have you ever had a broken bone (fracture)?  |
| e.    | ( )        | ( )       | Have you ever had a cast, splint, or had to use crutches?  |
| f.    | ( )        | ( )       | Must you use special equipment for competition (pads, braces, neck roll, etc.)?                    |
| 12.   | ( )        | ( )       | Has it been more than 5 years since your last tetanus booster shot?                                |
| 13.   | ( )        | ( )       | Are you worried about your weight?   |
| 14.   | ( )        | ( )       | FEMALES: Have you any menstrual problems?  |
| 15.   | ( )        | ( )       | Have you any medical concerns about participating in your sport?                                   |

\*\*\*\*\*ATHLETE SHOULD NOT WRITE BELOW THIS LINE\*\*\*\*\*

EXAMINER'S COMMENTS ON ALL "YES" ANSWERS (REFER TO QUESTION NUMBER):

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I permission for any above-named child to participate in the sport(s) approved by the examiner under the auspices of the Colton Schools, and authorize the coach or other responsible official to obtain emergency medical care for my child should such become necessary during participation and I am not immediately available.

Date \_\_\_\_\_ Parent/Guardian \_\_\_\_\_

Colton High School  
Whitman County Department of Health  
Sports Physical

NAME: \_\_\_\_\_ SCHOOL: \_\_\_\_\_

GRADE: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ FT \_\_\_\_\_ IN      WEIGHT: \_\_\_\_\_ AGE: \_\_\_\_\_

PULSE: \_\_\_\_\_ BP: \_\_\_\_\_ VISUAL ACUITY: LEFT 20/ \_\_\_\_\_ RIGHT 20/ \_\_\_\_\_

UA: \_\_\_\_\_ HEMATOCRIT: \_\_\_\_\_

	Normal	Abnormal	Describe
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	( )	( )	_____

Name \_\_\_\_\_

- Recommendation:
- ( ) No contraindication to participation.
  - ( ) Has following limitations, but may participate:
  - ( ) Participation contraindicated for following reasons:

I certify that I have on this date examined this pupil and find him/her physically able to compete in supervised interscholastic activities NOT CROSSED OUT BELOW:

BASEBALL, BASKETBALL, CROSS COUNTRY, FOOTBALL, GOLF, GYMNASTICS, SOCCER, SOFTBALL, SWIMMING, TENNIS, TRACK, VOLLEYBALL, WRESTLING, OTHER\_\_\_\_\_

DATE\_\_\_\_\_ EXAMINER'S SIGNATURE\_\_\_\_\_