GREENBRIER SCHOOL DISTRICT PHYSICAL EVALUATION

Page 1 – To be completed by student and/or guardian

Name _____ Sex ____ Age ____ Grade _____ Date of Birth _____

Parent's Name _____ Phone _____

Physician's Name _____ Phone _____

1. Have you ever been hospitalized? ☐Yes ☐No
2. Have you ever had surgery? ☐Yes ☐No
3. Are you presently taking any medications or pills? ☐Yes ☐No
4. Do you have any allergies (medicine, bees or other stinging insects?) ☐Yes ☐No
5. Have you ever passed out during or after exercise? ☐Yes ☐No
6. Have you ever been dizzy during or after exercise? ☐Yes ☐No
7. Do you tire more quickly than your friends during exercise? ☐Yes ☐No
8. Have you ever had high blood pressure? ☐Yes ☐No
9. Have you ever been told that you have a heart murmur? ☐Yes ☐No
10. Have you ever had racing of your heart or skipped heartbeats? ☐Yes ☐No
11. Has anyone in your family died of heart problems or a sudden death before age 50? ☐Yes ☐No
12. Do you have any skin problems (itching, rashes, acne)? ☐Yes ☐No
13. Have you ever had a head injury? ☐Yes ☐No
14. Have you ever been knocked out or unconscious? ☐Yes ☐No
15. Have you ever had a seizure? ☐Yes ☐No
16. Have you ever had a stinger, burner or pinched nerve? ☐Yes ☐No
17. Have you ever had heat or muscle cramps? ☐Yes ☐No
18. Have you ever been dizzy or passed out in the heat? ☐Yes ☐No
19. Do you have trouble breathing or do you cough during or after activity? ☐Yes ☐No
20. Do you use any special equipment (pads, braces, neck rolls, mouth guards, eye guards, etc.)? ☐Yes ☐No
21. Have you ever had any problems with your eyes or vision? ☐Yes ☐No
22. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? ☐Yes ☐No

    ☐Head ☐Shoulder ☐Thigh ☐Neck ☐Elbow
    ☐Knee ☐Chest ☐Foot ☐Forearm ☐Shin/Calf
    ☐Back ☐Wrist ☐Ankle ☐Hip ☐Hand
23. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)? ☐Yes ☐No
24. Have you had a medical problem or injury since your last evaluation? ☐Yes ☐No
25. When was your last tetanus shot?
26. When was your last measles immunization?
27. When was your first menstrual period?
28. When was your last menstrual period?
29. What was the longest time between your periods last year?

Explain any "Yes" answers here:

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

Date _____ Signature of Athlete _____

Signature of Parent/Guardian_____

GREENBRIER SCHOOL DISTRICT PHYSICAL EVALUATION

Name _____ Age ____ Date of Birth _____

PHYSICAL EXAM

To be completed by physician

Height _____ Weight _____ BP_____/_____ Pulse_____

Vision R 20/_____ L 20/_____ Corrected __Yes __No Pupils _____

		Normal	Abnormal Findings	Initials
LIMITED	Cardiopulmonary			
	Pulse			
	Heart			
	Lungs			
COMPLETE	Abdominal			
	Genitalia			
	Musculoskeletal			
	Neck			
	Shoulder			
	Elbow			
	Wrist			
	Hand			
	Back			
	Knee			
	Ankle			
	Foot			
	Other			

CLEARANCE

A. Cleared
B. Cleared after completing evaluation/rehabilitation for: _____
C. Not cleared for: __Collision __Contact __Noncontact
__Strenuous __Moderately Strenuous __Nonstrenuous

Due to: _____

RECOMMENDATION: _____

Signature of Physician: _____ Date: _____

Name of Physician: _____ Phone: _____