GREENBRIER SCHOOL DISTRICT PHYSICAL EVALUATION

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

2. Have you ever had surgery? 3. Are you presently taking any medications or pills? 4. Do you have any allergies (medicine, bees or other stinging insects?) 5. Have you ever passed out during or after exercise? 6. Have you ever been dizzy during or after exercise? 7. Do you tire more quickly than your friends during exercise? 8. Have you ever had high blood pressure? 9. Have you ever been told that you have a heart murmur? 10. Have you ever had racing of your heart or skipped heartbeats? 11. Has anyone in your family died of heart problems or a sudden death before age 50? 12. Do you have any skin problems (itching, rashes, acne)? 13. Have you ever had a head injury? 14. Have you ever had a seizure? 15. Have you ever had a seizure? 16. Have you ever had a seizure? 17. Have you ever had a seizure? 18. Have you ever had heat or muscle cramps? 19. Do you have trouble breathing or do you cough during or after activity? 20. Do you use any special equipment (pads, braces, neck rolls, mouth guards, eye guards, etc.)? 21. Have you ever bad any problems with your eyes or vision? 22. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? — Head _Shoulder _Thigh _Neck _Elbow _Knee _Chest _Foot _Forearm _Shin/Calf _Hand 23. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)? _Yes _No	Name _		Sex	Age	Grade _	Date of Birth		
Physician's Name	Parent'	s Name			Pho	ne		
1. Have you ever heen hospitalized? 2. Have you ever had surgery? 3. Are you presently taking any medications or pills? 4. Do you have any allergies (medicine, bees or other stinging insects?) 5. Have you ever passed out during or after exercise? 6. Have you ever passed out during or after exercise? 7. Do you tire more quickly than your friends during exercise? 7. Do you tire more quickly than your friends during exercise? 8. Have you ever had high blood pressure? 9. Have you ever had racing of your heart or skipped heartbeats? 10. Have you ever had racing of your heart or skipped heartbeats? 11. Has anyone in your family died of heart problems or a sudden death before age 50? 12. Do you have any skin problems (litching, rashes, acne)? 13. Have you ever had a head injury? 14. Have you ever had a seizure? 15. Have you ever had a seizure? 16. Have you ever had a stinger, burner or pinched nerve? 17. Have you ever had a stinger, burner or pinched nerve? 18. Have you ever had heat or muscle cramps? 19. Do you have trouble breathing or do you cough during or after activity? 29. No 20. Do you use any special equipment (pads, braces, neck rolls, mouth guards, eye guards, etc.)? 29. Have you ever had any problems with your eyes or vision? 21. Have you ever had any problems with your eyes or vision? 22. Have you ever had any problems with your eyes or vision? 23. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)? 24. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)? 25. When was your last tetanus shot? 26. When was your last measles immunization? 27. When was your last measles immunization? 28. When was your last measles immunization? 29. What was the longest time between your periods last year? 29. What was the longest time between your periods last year? 29. What was the longest time between your periods last year? 29. Explain any "Yes" answers here:								
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Signature of Parent/Guardian	Date _	Signature of Athle	ete					
		Signature of Pare	nt/Guar	dian			_	

GREENBRIER SCHOOL DISTRICT PHYSICAL EVALUATION

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. 486 =		
Name	Age	Date of Birth

PHYSICAL EXAM

To be completed by physician

		Height	Weight	BP			Pulse	
COMPLETE		Vision R 20/ L 20/		Corr	CorrectedYesNo Pupils			
				Nor		Abnorma		Initials
	LIMITED	Cardiopulmonary	1					
		Pulse						
		Heart						
		Lungs						
		Abdominal						
		Genitalia						
		Musculoskeletal						
		Neck						
		Shoulder						
		Elbow						
		Wrist						
		Hand						
		Back						
		Knee						
		Ankle						
		Foot						
		Other						
í	ARAN A. Cle B. Cle	eared eared after completi	ng evaluation/rehabilit	cation for:				
(C. NO	ot cleared for:	Collision Strenuous	Contact Moderately St	renuous	Noncon Nonstre		
	_		Strendods	ivioucitately 3th	Chaoas		.114043	
	Du	ue to:						
RECO	OMME	NDATION:						
Signa	ature (of Physician:)ate:			
Name of Physician: Phone:								