Whitney High School

Physical Evaluation – Page 2 (to be completed by physician)

Student Name: _____

Date of Birth: _____

Height: _____

Weight: _____

Blood Pressure: _____

Pulse: _____

Vision: Right 20/____ Left 20/____

Corrected: _____

Pupils: _____

Allergies: _____

Category	Normal	Abnormal	Initials
Cardiopulmonary			
Pulses			
Heart			
Lungs			
Tanner Stage (1-5)			
Skin			
Abdominal			
Genitalia			
Musculoskeletal			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			
Other			

Clearance (check the appropriate box below):

- ☐ Cleared
- ☐ Cleared after completing evaluation/rehabilitation for: _____
- ☐ Not cleared for (please circle appropriate box)
  - Collision
  - Contact
  - Non-contact

Recommendation: _____

_____

_____

Physician Name: _____

Physician Phone: _____

Signature of Physician: _____ Date: _____

Whitney High School

Physical Evaluation – Page 1 (to be completed by parent/guardian)

Student Name: _____

ID # (7 digit): _____

Date of Birth: _____

Gender: Male ____ Female ____ (Check one)

Sport(s): _____

Grade Level: 9 10 11 12 (Circle one)

Physician Name: _____

Physician phone: _____

Medical Ins. _____

Policy Number: _____

Complete the information below.

Yes ____ No ____ Have you ever been hospitalized?
Yes ____ No ____ Have you ever had surgery?
Yes ____ No ____ Are you presently taking any medication?
Yes ____ No ____ 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 ____ Have you ever had high blood pressure?
Yes ____ No ____ Have you ever had racing of your heart or skipped heartbeats?
Yes ____ No ____ Has anyone in your family died of heart problems or a sudden death before age 50?
Yes ____ No ____ Do you have any skin problems (itching, rashes, etc.)?
Yes ____ No ____ Have you ever had a head injury?
Yes ____ No ____ Have you ever been knocked out of unconscious?
Yes ____ No ____ Have you ever had a seizure?
Yes ____ No ____ Have you ever had a stinger, burner, or pinched nerve?
Yes ____ No ____ Have you ever had heat or muscle cramps?
Yes ____ No ____ Have you ever been dizzy or passed out in the heat?
Yes ____ No ____ Do you have trouble breathing or do you cough during or after activity?
Yes ____ No ____ Do you use any special equipment (pads, braces, mouth guard, eye guard, etc.)?
Yes ____ No ____ Have you had any problems with your eyes or vision?
Yes ____ No ____ Do you wear glasses, contacts, or protective eyewear?
Yes ____ No ____ Have you ever sprained, strained, dislocated, fractured, or had repeated swelling of any bones/joints?
Yes ____ No ____ Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?
Yes ____ No ____ Have you had a medical problem or injury since your last evaluation?
Yes ____ No ____ Are you missing any paired organs?

1. Explain any "yes" answers from above. _____
   _____
   _____
2. When was your last tetanus shot? _____
3. When was your last measles immunization? _____
4. Are there other medical concerns the athletic department needs to be aware of? _____
   _____

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

Signature of athlete: _____ Date: _____

Signature of parent/guardian: _____ Date: _____