# FRESHMAN & TRANSFER STUDENT PHYSICAL EVALUATION
# 2022-2023 SCHO OL YEAR

***To be completed by the Physician/Licensed Examiner for School:***

STUDENT NAME: _____ DATE OF BIRTH: _____ AGE: _____

**EXAMINATION**

Height:_____ Weight: _____ Pulse:_____ Blood Pressure: _____/_____

Vision R 20/_____L 20/_____ Corrected: Yes_____ No_____ Pupils: Equal _____ Unequal _____

Hearing: Normal_____ Referred_____ Spinal Exam: Normal_____Referred_____ % Body Fat (optional)_____

| MEDICAL | NORMAL | ABNORMAL FINDINGS |
|---|---|---|
| Appearance | | |
| Eyes/ears/nose/throat | | |
| Lymph nodes | | |
| Heart-Auscultation of the heart in the **supine** position | | |
| Heart-Auscultation of the heart in the **standing** position | | |
| Heart-lower extremity pulses | | |
| Pulses | | |
| Lungs | | |
| Abdomen | | |
| Genitalia (males only) | | |
| Skin | | |
| **MUSCULOSKELETAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Neck | | |
| Back | | |
| Shoulder/arm | | |
| Elbow/forearm | | |
| Wrist/hand/fingers | | |
| Hip/thigh | | |
| Knee | | |
| Leg/ankle | | |
| Foot/toes | | |

*The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.*

**CLEARANCE**

☐ Cleared for school physical activities including sports without restriction

☐ Not cleared for school physical activities including sports

☐ Pending further evaluation

Reason: _____

Recommendations: _____

_____

Physician/Clinician Signature: _____

Physician/Clinician Print Name: _____

Address:_____

Phone: _____ **Date of Exam**: _____

*Revised July 2021*

# FRESHMAN & TRANSFER STUDENT PHYSICAL EVALUATION
# 2022-2023 SCHOOL YEAR

## *To be completed by the Parent for Healthcare Provider:*

**DIRECTIONS: Complete questions below and explain "YES" answers in the space provided.**

| GENERAL QUESTIONS | YES | NO | UNSURE |
|---|---|---|---|
| 1. Has your doctor ever denied or restricted your participation in sports for any reason? | | | |
| 2. Do you have any ongoing medical conditions? If so check all that apply: □ Asthma □ Anemia □ Diabetes □ Infections □ Other:_____ | | | |
| 3. Have you ever spent the night in the hospital in the past year? | | | |
| 4. Have you ever had surgery? | | | |
| **HEART HEALTH QUESTIONS** | **YES** | **NO** | **UNSURE** |
| 5. Have you ever passed out or nearly passed out during or after exercise? | | | |
| 6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | | |
| 7. Does your heart ever race or skip beats (irregular beats) during exercise? | | | |
| 8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: □ High blood pressure □ High cholesterol □ Kawasaki disease □ A heart murmur □ A heart infection □ Other: _____ | | | |
| 9. Do you get lightheaded or feel more short of breath than expected during exercise? | | | |
| 10. Have you ever had an unexplained seizure? | | | |
| 11. Do you get more tired or short of breath more quickly than your friends during exercise? | | | |
| **FAMILY HEART HEALTH QUESTIONS** | **YES** | **NO** | **UNSURE** |
| 12. Has any family member or relative died of heart problems or unexpected sudden death before age 50? | | | |
| 13. Has any family member been diagnosed with a heart condition? | | | |
| **BONE AND JOINT QUESTIONS** | **YES** | **NO** | **UNSURE** |
| 14. Have you had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game? | | | |
| 15. Have you had any fractured bones or dislocated joints? | | | |
| 16. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast? | | | |
| 17. Do you regularly use a brace, orthotics or other assistive device? | | | |
| 18. Do any of your joints become painful, swollen, feel warm or look red? | | | |
| **MEDICAL QUESTIONS** | **YES** | **NO** | **UNSURE** |
| 19. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | | |
| 20. Do you have any allergies? If so, check all that apply: □ Pollen □ Medicine □ Food □ Stinging Insects □ Other: _____ | | | |
| 21. Are you missing any paired organs? | | | |
| 22. Have you had a severe viral infection (myocarditis, mononucleosis, etc.) in the past year? | | | |
| 23. Do you currently have any skin problems (itching, acne, warts, fungus, or blisters)? | | | |
| 24. Have you ever had a head injury or concussion? | | | |
| 25. Have you ever been knocked unconscious or lost memory? | | | |
| 26. Do you have a history of seizure disorder? | | | |
| 27. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | | | |
| 28. Have you ever become ill while exercising in the heat? | | | |
| 29. Have you been diagnosed with or treated for Sickle Cell Trait or Sickle Cell Disease? | | | |
| 30. Have you had any problems with your eyes or vision? | | | |
| 31. Have you ever had unexpected shortness of breath with exercise? | | | |
| 32. Have you had any eye injuries? | | | |
| 33. Do you use any special protective or corrective equipment? | | | |
| 34. Do you lose weight regularly to meet weight requirements for an extra-curricular activity? | | | |
| 35. Are you on a special diet or do you avoid certain foods? | | | |
| 36. Have you ever had an eating disorder? | | | |
| 37. Are you presently under a doctor's care? | | | |
| 38. Do you have any concerns you would like to discuss with a doctor? | | | |
| **FEMALES ONLY** | | | |
| 39. What year was your first menstrual cycle? | | | |
| 40. What month and day was your most recent menstrual cycle? | | | |
| 41. How many cycles have you had in the last 12 months? | | | |
| **COVID-19 MEDICAL QUESTIONS** | | | |
| 42. Have you been diagnosed with COVID-19 at any time? | | | |
| 43. Have you been hospitalized at any time due to COVID-19? | | | |