KENNEWICK SCHOOL DISTRICT

Kennewick School District 17
PHYSICAL EVALUATION

Section A: To Be Completed By Parent

☐ Male ☐ Female

Student Legal Name _____

Address City_____ Zip_____ Phone _____

Grade in the Fall_____ School in the Fall _____

Activity: Fall_____ Winter_____ Spring _____

Explain all "Yes" answers with dates and details in the area following the question.

Yes	No	
		Have you had any illness/injury recently, or do you have an illness/injury now? Explain
		Have you had a medical problem, illness or injury since your last exam?
		Do you have any chronic or recurrent illness? List
		Have you ever hand any illness lasting more than a week? List
		Have you ever been hospitalized overnight?
		Have you ever had surgery other than a tonsillectomy? List
		Have you ever had any injuries requiring treatment by a physician? List
		Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc)? List
		Are you presently taking ANY medications (including birth control pill, vitamin, aspirin, etc)? List
		Do you have ANY allergies (medicine, bees, foods, etc)? List
		Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?
		Do you tire more easily or quickly than your friends during exercise?
		Have you ever had any problem with your blood pressure or your heart?
		Have any of your close relatives had heart problems, heart attack or sudden death before they were age 50?
		Do you have any skin problems (acne, itching, rashes, etc)? List
		Have you ever had fainting, convulsions, seizures or severe dizziness?
		Do you have frequent severe headaches?
		Have you ever had a "stinger" or "burner" or pinched nerve?
		Have you ever been "knocked out" or "passed out"? Date & details
		Have you ever had a neck or head injury? Date and severity
		Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems?
		Have you had asthma, trouble breathing, or cough during or after exercise?
		Do you wear glasses or contacts or protective eye wear?
		Have you had any problems with your eyes or vision?
		Do you wear any dental appliance such as braces, bridge, plate, retainer?
		Have you ever had a knee injury?
		Have you ever had an ankle injury?

Student Name (Last, First)_____ Expiration Date_____

		Have you ever injured any other joint (shoulder, wrist, fingers, etc)?
		Have you ever had a broken bone (fracture)?
		Have you ever had a cast, splint, or had to use crutches?
		Must you use special equipment for competition (pads, braces, neck roll, etc)?
		Has it been more than five (5) years since your last tetanus booster shot?
		Are you worried about your weight?
		Females: Have you any menstrual problems?
		Have you any medical concerns about participating in your activity?

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

Student Signature_____ **Date**_____

Parent/Guardian Signature_____ **Date** _____

Section B: To Be Completed By Physician

Age_____ Height_____ Weight_____ BP_____ Pulse_____ Visual Acuity L 20/ R 20/_

	Normal	Abnormal Findings	Initials
Head			
Eyes, ENT			
Teeth			
Chest			
Lungs			
Heart			
Abdomen			
Genitalia			
Neurologic			
Skin			
Physical Maturity			
Spine, Back			
Shoulders, Upper Extremities			
Lower Extremities			

Assessment: ❑ Full Participation

❑ Limited Participation (describe limitations, restrictions in box below)

❑ Participation contraindicated (list reasons in box below)

Date_____ Physician's Signature_____ Print Physician Name _____

RW; lh January 2018