WYOMING HIGH SCHOOL ACTIVITIES ASSOCIATION

SCHOOL PHYSICAL EXAMINATION - MEDICAL RECORD

PHYSICIANS STATEMENT MUST BE DATED AFTER **MAY 1** TO BE VALID FOR THE UPCOMING SCHOOL YEAR

Name_____ Sex_____ Age_____ Date of Birth_____

Grade_____ School_____Sport(s)_____

Address _____ Phone_____

Personal Physician_____

In case of emergency, contact

Name_____ Relationship _____Phone (H)_____ (W)_____

Yes	No	
☐	☐	1. Have you had a medical illness or injury since your last check up or sports physical?
☐	☐	2. Have you ever been hospitalized overnight?
☐	☐	3. Are you currently taking any prescription of nonprescription (over-the-counter) medications or pills or using an inhaler?
☐	☐	4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?
☐	☐	5. Have you ever passed out during or after exercise?
☐	☐	Have you ever been dizzy during or after exercise?
☐	☐	Have you ever had chest pain during or after exercise?
☐	☐	Do you get tired more quickly than your friends do during exercise?
☐	☐	Have you ever had racing of your heart or skipped heartbeats?
☐	☐	Have you had high blood pressure or high cholesterol?
☐	☐	Have you ever been told you have a heart murmur?
☐	☐	Has any family member or relative died of heart problems or of sudden death before age 50?
☐	☐	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?
☐	☐	Has a physician ever denied or restricted your participation in sports for any heart problems?
☐	☐	6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?
☐	☐	7. Have you ever had a head injury or concussion?
☐	☐	Have you ever been knocked out, become unconscious, or lost your memory?
☐	☐	Have you ever had a seizure?
☐	☐	Do you have frequent or severe headaches?
☐	☐	Have you ever had numbness or tingling in your arms, hands, legs, or feet?
☐	☐	Have you ever had a stinger, burner, or pinched nerve?
☐	☐	8. Have you ever become ill from exercising in the heat?
☐	☐	9. Do you cough, wheeze, or have trouble breathing during or after activity?
☐	☐	Do you have asthma?
☐	☐	Do you have seasonal allergies that require medical treatment?
☐	☐	10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?
☐	☐	11. Have you had any problems with your eyes or vision?
☐	☐	Do you wear glasses, contacts, or protective eyewear?
☐	☐	12. Have you ever had a sprain, strain, or swelling after injury?
☐	☐	Have you broken or fractured any bones or dislocated any joints?
☐	☐	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?

If yes, check appropriate box and explain below

☐ Head	☐ Elbow	☐ Hip	☐ Neck	☐ Forearm	☐ Thigh	☐ Back
☐ Wrist	☐ Knee	☐ Chest	☐ Hand	☐ Shin/calf	☐ Shoulder	☐ Finger
☐ Ankle	☐ Upper Arm	☐ Foot				

☐	☐	13. Do you want to weigh more or less than you do now?
☐	☐	Do you lose weight regularly to meet weight requirements for your sport?
☐	☐	14. Do you feel stressed out?

15. Record the dates of your most recent immunizations (shots) for:

Tetanus _____ Measles _____ Hepatitis B_____ Chickenpox_____

FEMALES ONLY

16. When was your first menstrual period? _____

When was your most recent menstrual period? _____

How much time do you usually have from the start of one period to the start of another? _____

How many periods have you had in the last year? _____

What was the longest time between periods in the last year? _____

Explain "Yes" answers here:

_____

_____

_____

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

Signature of athlete_____ Signature of parent/guardian_____ Date_____

WYOMING HIGH SCHOOL ACTIVITIES ASSOCIATION

SCHOOL PHYSICAL EXAMINATION - MEDICAL RECORD

PHYSICIANS STATEMENT MUST BE DATED AFTER **MAY 1** TO BE VALID FOR THE UPCOMING SCHOOL YEAR

DATE OF EXAM _____

Name _____ Date of Birth _____

Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP _____ / _____(_____ / _____ ,_____ /_____)

Vision R 20/_____ L 20/ _____ Corrected: ☐ Y ☐ N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL
MEDICAL		
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand		
Hip/thigh		
Knee		
Leg/ankle		
Foot		

*Normal indicated by check or N

Cleared

*** Cleared after completing evaluation/rehabilitation for: _____**

_____

_____

_____

_____

* **Not cleared for: _____Reason:_____**

Recommendations:

_____

_____

_____

_____

***IF THESE BOXES ARE CHECKED, A COPY OF THIS FORM NEEDS TO BE SENT TO THE APPROPRIATE SCHOOL DISTRICT.**

Name of physician (print/type) _____ Date_____

Address _____ Phone _____

Signature of physician _____