

**VASHON ISLAND SCHOOL DISTRICT
PREPARTICIPATION HISTORY AND PHYSICAL EXAMINATION**

Name: _____ Birth Date: _____ Exam Date: _____ Grade 7 8 9 10 11 12

Address: _____ City: _____ Zip: _____ Gender M F

Phone: _____ SCHOOL _____

Middle School physicals are NOT valid for High School interscholastic activities. This physical is good for 2 years.

HISTORY

- | Yes | No | |
|--------------------------------|--------------------------|--|
| 1 a. <input type="checkbox"/> | <input type="checkbox"/> | Have you had any illness/injury recently, or do you have an illness/injury now? |
| b. <input type="checkbox"/> | <input type="checkbox"/> | Have you had a medical problem, illness or injury since your last exam? |
| c. <input type="checkbox"/> | <input type="checkbox"/> | Do you have any chronic or recurrent illness? |
| d. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any illness lasting more than a week? |
| e. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hospitalized overnight? |
| f. <input type="checkbox"/> | <input type="checkbox"/> | Have you had any surgery other than tonsillectomy? |
| g. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any injuries requiring treatment by a physician? |
| h. <input type="checkbox"/> | <input type="checkbox"/> | Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc.)? |
| 2. <input type="checkbox"/> | <input type="checkbox"/> | Are you presently taking ANY medications (including birth control pill, vitamin, aspirin, etc.)? |
| 3. <input type="checkbox"/> | <input type="checkbox"/> | Do you have ANY allergies (medicines, bees, foods, or other factors)? |
| 4 a. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had chest pain, dizziness, fainting, passing out during or after exercise? |
| b. <input type="checkbox"/> | <input type="checkbox"/> | Do you tire more easily or quickly than your friends during exercise? |
| c. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any problem with your blood pressure or your heart? |
| d. <input type="checkbox"/> | <input type="checkbox"/> | Have any close relatives had heart problems, heart attack or sudden death before they were age 50? |
| 5. <input type="checkbox"/> | <input type="checkbox"/> | Do you have any skin problems (acne, itching, rashes, etc.)? |
| 6 a. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had fainting, convulsions, seizures or severe dizziness? |
| b. <input type="checkbox"/> | <input type="checkbox"/> | Do you have frequent severe headaches? |
| c. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a "stinger" or "burner" or "pinched nerve"? |
| d. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been "knocked out" or "passed out"? |
| e. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a neck or head injury? |
| 7. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems? |
| 8. <input type="checkbox"/> | <input type="checkbox"/> | Have you had asthma, or trouble breathing, or cough during or after exercise? |
| 9 a. <input type="checkbox"/> | <input type="checkbox"/> | Do you wear eyeglasses, contact lenses or protective eye wear? |
| b. <input type="checkbox"/> | <input type="checkbox"/> | Have you had any problem with your eyes or vision? |
| 10. <input type="checkbox"/> | <input type="checkbox"/> | Do you wear any dental appliance such as braces, bridge, plate, retainer? |
| 11 a. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a knee injury? |
| b. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an ankle injury? |
| c. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever injured any other joint (shoulder, wrist, fingers, etc.)? |
| d. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a broken bone (fracture)? |
| e. <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a cast, splint, or had to use crutches? |
| f. <input type="checkbox"/> | <input type="checkbox"/> | Must you use special equipment for competition (pads, braces, neck roll, etc.)? |
| 12. <input type="checkbox"/> | <input type="checkbox"/> | Has it been more than 5 years since your last tetanus booster shot? |
| 13. <input type="checkbox"/> | <input type="checkbox"/> | Are you worried about your weight? |
| 14. <input type="checkbox"/> | <input type="checkbox"/> | FEMALES: Have you any menstrual problems? |
| 15. <input type="checkbox"/> | <input type="checkbox"/> | Have you any medical concerns about participating in your sport? |

***** ATHLETE SHOULD NOT WRITE BELOW THIS LINE *****

EXAMINER'S COMMENTS ON ALL "YES" ANSWERS (refer to question number):

WIAA Regulations – Physical Examination – Prior to the first practice for participation in interscholastic athletics in a middle level school and prior to participation in a high school, a student shall undergo a thorough medical examination and be approved for interscholastic athletic competition by a medical authority licensed to perform a physical examination. This physical examination must include, but not necessarily be limited to:

- A. Documentation of a detailed review of the student's medical history with special attention to presence or absence of cardiovascular/pulmonary risks and/or previous significant injury and rehabilitation there from.
- B. Documentation of satisfactory examination of the cardiopulmonary system.
- C. Documentation of satisfactory sport specific orthopedic screening examination.
- D. A written statement by the examiner as to the fitness of the student to undertake the proposed athletic participation, together with suggestion for activity modification necessary.

PHYSICAL EXAMINATION

Mandatory for Wrestling

Age: _____ Pulse: _____
 Height: _____ Blood Pressure: _____
 Weight: _____ Visual Acuity: Left 20/ _____ Right 20/ _____

Urinalysis:
 Body Fat %
 HCT:
 EST VO2 Max:
 Audiometry:

Normal		Abnormal
<input type="checkbox"/>	1. Head	<input type="checkbox"/>
<input type="checkbox"/>	2. Eyes (pupils), ENT	<input type="checkbox"/>
<input type="checkbox"/>	3. Teeth	<input type="checkbox"/>
<input type="checkbox"/>	4. Chest	<input type="checkbox"/>
<input type="checkbox"/>	5. Lungs	<input type="checkbox"/>
<input type="checkbox"/>	6. Heart	<input type="checkbox"/>
<input type="checkbox"/>	7. Abdomen	<input type="checkbox"/>
<input type="checkbox"/>	8. Genitalia	<input type="checkbox"/>
<input type="checkbox"/>	9. Neurologic	<input type="checkbox"/>
<input type="checkbox"/>	10. Skin	<input type="checkbox"/>
<input type="checkbox"/>	11. Physical Maturity	<input type="checkbox"/>
<input type="checkbox"/>	12. Spine, Back	<input type="checkbox"/>
<input type="checkbox"/>	13. Shoulders, Upper extremities	<input type="checkbox"/>
<input type="checkbox"/>	14. Lower extremities	<input type="checkbox"/>

Assessment: Full participation
 Limited participation (describe limitations, restrictions): _____

Participation contraindicated (list reasons): _____

Recommendations (equipment, taping, rehabilitation, etc.): _____

EXAMINER'S CERTIFICATION:

I hereby certify that the above-named individual's physical condition is adequate to participate in supervised interscholastic activities NOT CROSSED OUT BELOW:

BASEBALL BASKETBALL CROSS COUNTRY FOOTBALL GOLF SOCCER FASTPITCH
 CHEERLEADING TENNIS TRACK VOLLEYBALL WRESTLING Other _____

DATE: _____ EXAMINER'S SIGNATURE: _____

EXAMINER'S PHONE: () _____ PRINT EXAMINER'S NAME: _____

**MEDICAL AUTHORITIES LICENSED TO GIVE
 PHYSICAL EXAMINATIONS**

1. Medical Doctor (MD)	4. Medics - Physician Assistant (P.A.)
2. Doctor of Osteopathy (D.O.)	5. Naturopaths (N.D.)
3. Certified Nurse Practitioner (CRN)	