

Anchorage School District Sports Physical - Health Examination Form

MEDICAL HISTORY TO BE COMPLETED BY LEGAL PARENT/GUARDIAN

Last Name (print) _____ First Name _____ Initial _____ Date of Birth _____

1. Have you ever been hospitalized? Y ___ N ___
2. Have you ever had surgery? Y ___ N ___
3. Are you presently taking any medications or pills? Y ___ N ___
4. Have you ever passed out during or after exercise? Y ___ N ___
5. Have you ever been dizzy during or after exercise? Y ___ N ___
6. Have you ever had chest pain during or after exercise? Y ___ N ___
7. Do you tire more quickly than your friends during exercise? Y ___ N ___
8. Have you ever had high blood pressure? Y ___ N ___
9. Have you ever been told that you have a heart murmur? Y ___ N ___
10. Have you ever had racing of your heart or skipped beats? Y ___ N ___
11. Has anyone in your family died of heart problems or sudden death before age 50? Y ___ N ___
12. Do you have any skin problems (itching, rashes, acne)? Y ___ N ___
13. Have you ever had a head injury? Y ___ N ___
14. Have you ever had a concussion? If yes, how many _____ Y ___ N ___
15. Have you ever been knocked out or unconscious? Y ___ N ___
16. Do you suffer from migraines? Y ___ N ___
17. Have you ever had a seizure? Y ___ N ___
18. Have you ever had a stinger, burner or pinched nerve? Y ___ N ___
19. Have you ever had heat or muscle cramps Y ___ N ___
20. Have you ever been dizzy or passed out in the heat? Y ___ N ___
21. Do you have trouble breathing or do you cough during or after activity? Y ___ N ___
22. Do you use any special equipment (pads, braces, neck rolls, mouth guards, eye guards, etc.)? Y ___ N ___
23. Have you ever had problems with your eyes or vision? Y ___ N ___
24. Do you wear glasses or contacts or protective eye wear? Y ___ N ___
25. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries in any of the following bones or joints? Y ___ N ___
 ___ Head ___ Thigh ___ Elbow ___ Chest ___ Shin/calf ___ Wrist ___ Hip
 ___ Shoulder ___ Neck ___ Knee ___ Forearm ___ Back ___ Ankle ___ Hand
26. Have you ever had other medical problems (infectious mononucleosis, diabetes, etc.) Y ___ N ___
27. Have you had any medical problem or injury since your last evaluation? Y ___ N ___
28. Are you Diabetic? Y ___ N ___
29. Are you Asthmatic? Y ___ N ___
30. Do you have any allergies (medicine, bees or other stinging insects) _____ Y ___ N ___

List all allergies: _____

31. Explain all "yes" answers _____

Consent information:

- I hereby consent to emergency treatment, hospitalization or other medical treatment as may be necessary by a physician, qualified nurse, or hospital in the event of an injury or illness.
- I hereby consent to participation in ASAA approved interscholastic activities.
- I hereby consent to travel to and from ASAA activities via school approved transportation.
- I hereby waive on behalf of myself and the above student any liability of the school or ASAA organizationally or for any of its officers, agents or employees for injuries sustained in the interscholastic program.
- I accept financial responsibility for the above student in the event of an injury or illness.
- I hereby state that information submitted on this form is true.
- I hereby consent to abiding by the ASAA rules and regulations and school handbook.
- I understand that the medical information disclosed by the medical provider to the school may be further disclosed by the school to the school's administrators, athletic director, coaches and athletic trainers of any interscholastic activities in which I seek to participate.

Student Signature _____ Parent Signature _____ Date _____

HEALTH EXAMINATION TO BE COMPLETED BY HEALTHCARE PROVIDER - MD, DO, ANP, PA

Age _____ Height _____ Weight _____ Blood Pressure _____

Vision R/20 _____ Vision L/20 _____

Circle any of the following that are abnormal and explain under "comments":

- | | | |
|-----------------------|-------------------------------|-----------------------|
| Eyes/ears/nose/throat | Genitalia, Tanner stage _____ | Knee/hip |
| PERRLA | Neurological | Back |
| Respiratory | Skin | Ankles |
| Cardiovascular | Head/neck | Other musculoskeletal |
| Liver/spleen/abdomen | LAB: UA, HGB/HCT (as needed) | DT (date): _____ |

Comments: _____

I certify that on this date, I have examined this student and find him/her physically able to compete in all supervised activities not crossed out:

- | | | | |
|---------------|----------------|-----------------|------------|
| Baseball | Football | Softball | Wrestling |
| Basketball | Gymnastics | Swimming | XC running |
| Bowling | Hockey (boys) | Tennis | XC skiing |
| Cheer | Hockey (girls) | Track & Field | |
| Diving | Riflery | Volleyball | |
| Flag Football | Soccer | Weight Training | |

HCP Name (MD, DO, ANP, PA) (print) _____

Signature _____ Date of exam _____

Address _____ **Healthcare provider stamp is required here**

City _____ State _____

Phone _____ Zip _____