**PHYSICAL EXAMINATION**

Name ___________________________________________________ Age ____  Date _________________

<table>
<thead>
<tr>
<th></th>
<th>Normal</th>
<th>Abnormal Findings</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height</td>
<td>_______</td>
<td>_______</td>
<td></td>
</tr>
<tr>
<td>Weight</td>
<td>_______</td>
<td>_______</td>
<td></td>
</tr>
<tr>
<td>BP _____/ _____</td>
<td>Pulse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision R20/ _____</td>
<td>L20/</td>
<td></td>
<td>Y N</td>
</tr>
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</table>

Corrected: Y N

- **HEENT**
- **Pupils equal**
- **Heart**
- **Pulses**
- **Lungs**
- **Abdominal**
- **Testicles/hernia**

**Musculoskeletal (Symmetry/ROM/Strength/Flexibility)**

- **Neck**
- **Back**
- **Shoulder**
- **Elbow**
- **Wrist**
- **Hand**
- **Hip**
- **Knee** R MCL R ACL
- **L MCL L ACL**
- **Ankle** R ANT DRAWER
- **L ANT DRAWER**
- **Foot**

- No restriction for sports participation
- Clearance withheld pending attached verification of rehabilitation/evaluation for: ______________________________
- Limited participation. Not cleared for the following sports:
- Minimum high school wrestlers weight (circle): 75 79 83 89 90 93 96 99 103 112 119 125 130 135 140 145 152 160 171 189 215 UNL
- Was body fat measured? _______________

Recommendations: ________________________________________________________________________________

________________________________________________________________________________________________

Examiner’s Signature _________________________________  Date _______  Phone __________________________

Print Name and Address _____________________________________________________________________________

The information on this physical form will cover this student for the duration of **24 months**.
Spokane Public Schools

PRE PARTICIPATION PHYSICAL EXAM FORM

Name ________________________________________________________________  Date _____________________

Address __________________________________________________________________________________________________________________________________________________________

Phone ___________________________________________  Birthdate _________________________  Sex _________

Health Care Provider _______________________________  Health Care Phone  _______________________________

Sports __________________________________________  Grade _________________________________________

Notify in Emergency _______________________________  Emergency Phone  ________________________________

Alternate Emergency Name _________________________  Alternate Emergency Phone  ________________________

Medications (taken regularly) ____________________________________

____________________________________________________________

Last tetanus shot __________________  (year)

Allergies:

<table>
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<tr>
<th>Medicine</th>
<th>Bee Sting</th>
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Student must return this to the school office before practicing or competing.

History  Explain “Yes” answers below: Yes  No

1. Have you had a medical problem or injury since your last evaluation? .........................................................

2. Have you ever been in the hospital or had an operation ..............................................................................

3. Have you ever been dizzy or passed out during or after exercise?  ...............................................................

4. Have you ever had chest pain during or after exercise? ..............................................................................

5. Have you ever had high blood pressure, a heart murmer, or irregular heartbeats? ......................................

6. Has anyone in your family died of heart problems or a sudden death before age 50? ..................................

7. Have you ever been knocked out or unconscious, had a head injury, or a seizure? ....................................

8. Have you ever had a “stinger”, “burner”, or a pinched nerve? ......................................................................

9. Have you ever had muscle cramps, heat exaustion, or heat stroke? ...........................................................

10. Do you have trouble breathing or do you cough during or after activity? ...................................................

11. Have you ever had asthma, diabetes, mono, or other medical problems? ....................................................

12. Are you missing an eye, kidney, or testicle?  __________  ...........................................................................

13. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)? ...................

14. Have you ever had a sprain, strain, dislocation, stress fracture, joint swelling, or broken bone?................

☐ neck  ☐ back  ☐ shoulder  ☐ elbow  ☐ wrist  ☐ hand

☐ hip  ☐ thigh  ☐ knee  ☐ shin/calf  ☐ ankle  ☐ foot

15. Are you satisfied with your weight? ______________  ..................................................................................

16. At what age was your first menstrual period?  _____  Do you have at least eight periods in a year? ..........

Please explain “Yes” answers:

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

Parent/Guardian Please read and Sign

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

I approve of my child’s participation in athletics in the Spokane Public Schools athletic program, and I will assume all financial responsibilities not covered by my child’s school insurance for injuries received while he or she is training for or playing in athletic games. I also give my permission for my child to receive a physical examination. I give my permission for my son/daughter to travel as required as a member of the team(s) of which he/she is a member. I give my permission for emergency treatment of an injury by any physician designated by a school official. I understand that the signature and the information on this form will cover my son/daughter for the duration of 24 months.

____________________  _________________________  ____________________________

Date  Signature of Athlete  Signature of Parent/Guardian