

# 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 \_\_\_\_\_