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Form A

ANCHORAGE SCHOOL DISTRICT
SPORTS PHYSICAL ~ HEALTH EXAMINATION FORM A

MEDICAL HISTORY TO BE COMPLETED BY LEGAL PARENT/GUARDIAN

Last Name (print) _____ **First Name**_____**Initial**_____ **Date of birth**_____

Have you or any members of your family under age 50 ever had a heart attack or sudden death?	Y ☐	N ☐
Have you ever had any chest pain or passed out while exercising?	Y ☐	N ☐
Do you cough or have trouble breathing during or after exercise?	Y ☐	N ☐
Have you ever had an illness or injury that required hospitalization?	Y ☐	N ☐
Have you ever made repeated visits to a doctor for an illness or injury?	Y ☐	N ☐
Do you have any allergies?	Y ☐	N ☐
Are you presently taking any medications?	Y ☐	N ☐
In the past year, have you had a significant illness or injury? (i.e.: concussion)	Y ☐	N ☐

Explain any "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 accept legal responsibility of 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

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_____

Check 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 <u>not</u> crossed out:

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

HCP Name (MD, DO, ANP, PA) (print) _____ Signature_____ Date of exam_____
Address_____ **Healthcare provider stamp is required here**
City_____ State_____
Phone_____ Zip_____