



## Health History and Physical Exam

Part A: HEALTH HISTORY QUESTIONNAIRE: Completed by the parent/guardian and student and reviewed by examining provider.  
 Part B: PHYSICAL EVALUATION FORM: Completed by examining licensed provider.

### Part A: Health History Questionnaire

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Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Physician: \_\_\_\_\_ Physician Phone: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Date of last Physical: \_\_\_\_\_

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Please answer the following questions about the students medical history. Explain ALL yes answers in the space provided at the end of the questions.

**1. Have you ever had, or do you currently have:**

- a. Restriction from sports for a health related problem? Y/N/Dont Know
- b. An injury or illness since your last exam? Y/N/Dont Know
- c. A chronic or ongoing illness (such as diabetes or asthma)? Y/N/Dont Know
  - 1. Use an inhaler or other prescription medicine to control asthma? Y/N/Dont Know
  - \*If yes, you MUST fill out an Asthma Action Plan with your health care provider!
- d. Any prescribed or over the counter medications you take on a regular basis? Y/N/Dont Know
- e. Surgery, hospitalization or any emergency room visit(s)? Y/N/Dont Know
- f. Any allergies to medications? Y/N/Dont Know
- g. Any allergies to bee stings, pollen, latex or foods? Y/N/Dont Know
  - 1. If yes, check type of reaction:  Rash  Hives  Breathing or anaphylactic reaction
  - 2. Take any medication/Epipen for allergy symptoms? (List below) Y/N/Dont Know
  - \*If yes, you MUST fill out a Care Plan for Allergic Reaction form with your healthcare provider.
- h. Any anemias or blood disorders? Y/N/Dont Know
- i. A blood relative who died before age 50? Y/N/Dont Know

**2. Have you ever had, or do you currently have any of the following head-related conditions:**

- a. Concussion or head injury? Y/N/Dont Know
- b. Memory loss or been knocked out? Y/N/Dont Know
- c. A seizure? Y/N/Dont Know
- d. Frequent or severe headaches? Y/N/Dont Know
- e. Fuzzy or blurry vision? Y/N/Dont Know
- f. Sensitivity to light/noise? Y/N/Dont Know

**3. Have you ever had, or do you currently have any of the following heart-related conditions:**

- a. Chest pain or discomfort? Y/N/Dont Know
- b. Heart murmur? Y/N/Dont Know
- c. High blood pressure or elevated cholesterol level? Y/N/Dont Know
- d. Restriction from sports for heart problems? Y/N/Dont Know
- e. Heart infection? Y/N/Dont Know
- f. Dizziness or passing out after exercise with no known cause? Y/N/Dont Know
- g. Unexplained difficulty breathing or fatigue during exercise? Y/N/Dont Know
- h. Racing or skipped heart beats? Y/N/Dont Know
- i. Any family member or relative:
  - 1. Die of a heart problem before age 35? Y/N/Dont Know
  - 2. Die of a heart problem before age 50? Y/N/Dont Know
  - 3. Die with no known reason? Y/N/Dont Know
  - 4. Die while exercising? During or after? (Circle one) Y/N/Dont Know
  - 5. With Marfans Syndrome? Y/N/Dont Know

**4. Have you ever had, or do you currently have any of the following eye, ear, nose, mouth or throat conditions:**

- a. Vision problems? Y/N/Dont Know
  - 1. Wear contacts, eyeglasses or protective eye wear? (Circle which type) Y/N/Dont Know
- b. Hearing loss or problems? Y/N/Dont Know
  - 1. Wear hearing aides or implants? Y/N/Dont Know

- CONTINUED ON BACK -

- c. Nasal fractures or frequent nose bleeds? Y/N/Dont Know
- d. Wear braces, retainer or protective mouth gear? Y/N/Dont Know
- e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)? Y/N/Dont Know

**5. Have you ever had or do you currently have any of the following neuromuscular/orthopedic conditions:**

- a. Numbness, a burner, stinger or pinched nerve? Y/N/Dont Know
- b. A sprain? Y/N/Dont Know
- c. A strain? Y/N/Dont Know
- d. Swelling or pain in muscles, tendons, bones or joints? Y/N/Dont Know
- e. A dislocated joint(s)? Y/N/Dont Know
- f. Upper or lower back pain? Y/N/Dont Know
- g. Fracture(s) or stress fracture(s)? Y/N/Dont Know
- h. Do you wear any protective braces or equipment for any prior injury? Y/N/Dont Know

**6. Have you ever had or do you currently have any of the following general or exercise related conditions:**

- a. Difficulty breathing:
  - 1. During exercise? Y/N/Dont Know
  - 2. After running one mile? Y/N/Dont Know
  - 3. Coughing, wheezing or shortness of breath in weather changes? Y/N/Dont Know
  - 4. Exercise-induced asthma? Y/N/Dont Know
    - i. Controlled with medication? Y/N/Dont Know
    - ii. Experience dizziness, passing out or fainting? Y/N/Dont Know
- b. Viral infections (e.g. mono hepatitis)? Y/N/Dont Know
- c. Become tired more quickly than your friends? Y/N/Dont Know
- d. Any of the following skin conditions:
  - 1. Acne, contact dermatitis, ringworm, warts, herpes? Y/N/Dont Know
  - 2. Sun sensitivity? Y/N/Dont Know
- e. Recent weight gain/loss (greater than or less than 10 pounds)? Y/N/Dont Know
  - 1. Do you want to weigh more or less than you do now? Y/N/Dont Know
- f. Ever had feelings of depression? Y/N/Dont Know
- g. Heat-related problems (dehydration, dizziness, fatigue, headache)? Y/N/Dont Know
  - 1. Heat exhaustion (cool, clammy, damp skin)? Y/N/Dont Know
  - 2. Heat stroke (hot, red, dry skin)? Y/N/Dont Know
  - 3. Muscle Cramps? Y/N/Dont Know
- h. Absence or loss of an organ (e.g. kidney, eyeball, spleen)? Y/N/Dont Know

Explain all **YES** answers here (include relevant dates):

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Please check the appropriate boxes and sign below:

- I certify that the information provided above is accurate to the best of my knowledge as of the date of my signature.
- I give authorization for treatment if a parent cannot be reached.
- I give permission for the school nurse to share information concerning my child's health to those faculty/staff members on a need to know basis. I recognize that sharing this information is important to my child's well being.
- I give permission for appropriately trained personnel to administer the state required vision, hearing, BP, height, weight, and scoliosis screenings if the information is not provided by the child's healthcare professional.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Most recent immunizations/Dates:

Medications currently being used:

Additional Observations:

General Diagnosis: \_\_\_\_\_

Recommendations: \_\_\_\_\_

**THE HISTORY PREPARED BY THE PARENT/STUDENT MUST BE REVIEWED BY  
THE EXAMINING PROVIDER AT THE TIME OF THE PHYSICALEXAMINATION.**

**- CONTINUED ON NEXT PAGE -**

**CLEARANCES**

A. Student MAY participate in all sports without restriction

B. Student is **withheld clearance** for participation in any sport until evaluation / treatment of:

\_\_\_\_\_

\_\_\_\_\_

C. Student is cleared for participation in **limited types** of sports which **exclude** the following types of contact. (CHECK ALL THAT APPLY)

CONTACT/COLLISION  
 LIMITED CONTACT

NON-CONTACT/STRENUOUS  
 NON-CONTACT/NON-STRENUOUS

Contact/Collision	Limited Contact	Non-Contact	
		Strenuous	Non-Strenuous
Lacrosse	Baseball	Running/Cross-Country	Golf
Soccer	Basketball	Strength Training	
Wrestling	Fencing	Tennis	
	Skiing	Track	
	Softball		
	Volleyball		

**HISTORY REVIEWED AND STUDENT EXAMINED BY:**

Physician/Provider's Stamp:

Physician's/Provider's Signature \_\_\_\_\_

Today's Date \_\_\_\_\_

Date of Exam \_\_\_\_\_

**HISTORY REVIEWED BY:**

Name \_\_\_\_\_

Today's Date \_\_\_\_\_

Signature \_\_\_\_\_

Review Date \_\_\_\_\_