NATRONA COUNTY SCHOOL DISTRICT #1 PHYSICAL EXAMINATION FORM

Physicians Statement Must Be Dated AFTER MAY 1 to Be Valid For the Upcoming School Year

RED Areas Are To Be Completed By Parent and Student Prior to Physical Examination

STUDENT INFORMATION

School _____ Grade ____ DOB _____ Name _____ Gender M ☐ F ☐

SPECIFIC SPORT YOU WILL BE PARTICIPATING: Fall _____ Winter _____ Spring _____

CONSENT TO PARTICIPATE

☐ I/We, as legal guardians, give our permission for our child named above to participate in organized NCSD #1 athletics, realizing that such activity involves the potential for injury which is inherent in all sports. I/We acknowledge that even with the best coaching, use of the most advanced protective equipment and strict observance of rules, injuries are still a possibility. On rare occasion these injuries can be so severe as to result in total disability, paralysis or death.

CONSENT FOR EMERGENCY MEDICAL TREATMENT

☐ I/We as legal guardians, give our permission for NCSD#1 to sign for emergency treatment for our child named above. Parents/Guardians will be notified in case of serious illness or injury as quickly as possible, but this will make treatment possible. In case of emergency and parent cannot be reached contact:

Name _____ Phone _____ Physician _____ Phone _____

INSURANCE (Parent/Guardian please check one statement) Insurance is mandatory for anyone participating in athletics and/or cheerleading. NCSD #1 ***does not*** carry health or accident insurance for students.

☐ The child named above is ***not*** covered by an accident insurance policy and we wish to purchase insurance. Student insurance is available through a local carrier and forms can be obtained at the school office.

☐ The child named above ***is covered*** by an accident insurance policy, the policy will remain in effect during all activities our child is involved in, and we ***do not*** wish to purchase additional insurance.

Insurance Company _____ Policy # _____

PARENTAL INFORMATION

I/We as legal guardians, agree that should any information on this form (including physician exam record below) change during the course of the school year we will submit to school officials in writing, the change that has occurred immediately. I/We, as legal guardians, acknowledge that I/We have read and understand the content of the Athletic/Activity Clearance Form, have completed the Health History (back), and further understand that no participation will be allowed until this form is completed and returned to administrative personnel.

Signatures _____ _____

Parent/Guardian Student/Athlete

_____ _____ _____ _____

Work Phone Home Phone Address Date

PHYSICIAN'S EXAMINATION RECORD (Physician's Use Only) Physician, please check all blanks

Height		Ears		Blood Pressure	/	Spine & Posture	
Weight		Nose		Abdomen		Arms & Hands	
Eyes		Throat		Hernia		Legs & Knees	
Pupils		Teeth		Lymph Nodes		Feet & Ankles	
Vision R	/	Lungs		Testicular Exam		Other	
Vision L	/	Heart		Skin Conditions			

Corrected ☐ Y ☐ N

Physical Activity: ☐ Cleared without restrictions

☐ Cleared with restrictions (Please list)

☐ Not cleared (Reasons/Recommendations) _____

_____

_____ _____

PRINTED Name of Physician Address City State Zip

_____ _____ _____

Physician Signature Phone Date

PLEASE TURN IN TOGETHER: 1) COMPLETED PHYSICAL, 2) INSURANCE APPLICATION 3) INSURANCE PREMIUM PAYMENT TO THE SCHOOL ATHLETIC DIRECTOR/ATHLETIC/ACTIVITIES FACILITATOR-ML AT THE SAME TIME

Revised 01/05/15

MEDICAL/HEALTH HISTORY

Please explain "Yes" answers on bottom of page

Y	N		
☐	☐	1.	Have you ever been hospitalized?
☐	☐	a.	Have you ever had surgery?
☐	☐	2.	Are you presently taking any medications or pills?
☐	☐	3.	Do you have any allergies (medicine, bees or other stinging insects)?
☐	☐	4.	Have you ever passed out during or after exercise?
☐	☐	a.	Have you ever been dizzy during or after exercise?
☐	☐	b.	Have you ever had chest pain during or after exercise?
☐	☐	c.	Do you tire more easily that your friends during exercise?
☐	☐	d.	Have you ever had high blood pressure?
☐	☐	e.	Have you ever been told that you have a heart murmur?
☐	☐	f.	Have you ever had racing of your heart or skipped heartbeats?
☐	☐	g.	Has anyone in your family died of heart problems or a sudden death before age 50?
☐	☐	5.	Do you have any skin problems (itching, rashes, acne)?
☐	☐	6.	Have you ever had a head injury?
☐	☐	a.	Have you ever been knocked out, unconscious, or lost your memory?
☐	☐	b.	Have you ever had a seizure?
☐	☐	c.	Have you ever had a stinger, burner, pinched nerve, or numbness in extremities?
☐	☐	7.	Have you ever had heat or muscle cramps?
☐	☐	a.	Have you ever been dizzy, passed out, or become ill due to heat?
☐	☐	8.	Do you have trouble breathing or do you cough during or after activity?
☐	☐	9.	Do you use special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?
☐	☐	10.	Have you had any problems with your eyes or vision?
☐	☐	a.	Do you wear glasses or contacts or protective eye wear?

11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?

☐ Head ☐ Elbow ☐ Shoulder ☐ Neck ☐ Thigh ☐ Knee ☐ Foot

☐ Back ☐ Chest ☐ Forearm ☐ Wrist ☐ Ankle ☐ Hand ☐ Hip ☐ Shin/Calf

Y	N		
☐	☐	12.	Have you had any other medical problems (asthma, diabetes, mononucleosis, etc.)?
☐	☐	13.	Have you had a medical problem or injury since your last evaluation?

14. When was your first menstrual period? _____

a. When was your last menstrual period?

b. What was the longest time between your periods last year?

Y	N		
☐	☐	15.	Has a physician ever denied or restricted your participation in sports or any physical activity?

Explain all "Yes" answers

_____

_____

_____

_____

_____

_____

_____

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_____

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