WHITE RIVER SCHOOL DISTRICT

PHYSICAL FORM

Student's Name: ______________________________ **Grd:** ____ **Date:** ____________________

YES	NO		
☐	☐	1. a	Have you had any illness/injury recently, or do you have an illness /injury now?
☐	☐	b	Have you had a medical problem, illness or injury since your last exam?
☐	☐	c	Do you have any chronic or recurrent illnesses?
☐	☐	d	Have you ever had any illness lasting more than a week?
☐	☐	e	Have you ever been hospitalized overnight?
☐	☐	f	Have you had any surgery other than a tonsillectomy?
☐	☐	g	Have you had any injuries requiring treatment by a physician?
☐	☐	h	Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc.)?
☐	☐	2.	Are you presently taking any medication (including birth control, vitamin, aspirin, etc.)?
☐	☐	3.	Do you have any allergies (medicines, bees, food, or other factors)?
☐	☐	4. a	Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?
☐	☐	b	Do you tire more easily or quickly than your friends during exercise?
☐	☐	c	Have you ever had any problem with you blood pressure or your heart?
☐	☐	d	Have any relative(s) had heart problems, hear attack or sudden death before they were 50?
☐	☐	5.	Do you have any skin problems (acne, itching, rashes, etc.)?
☐	☐	6. a	Have you ever had fainting, convulsions, seizures or sever dizziness?
☐	☐	b	Do you have frequent severe headaches?
☐	☐	c	Have you ever had a "stinger" or "burner" or "pinched nerve"?
☐	☐	d	Have you ever been knocked out or passed out?
☐	☐	e	Have you ever had a neck or head injury?
☐	☐	7.	Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat related problems?
☐	☐	8.	Have you had asthma, or trouble breathing, or coughing during or after exercise?
☐	☐	9. a	Do you wear eyeglasses, contact lenses or protective eye wear?
☐	☐	b	Have you ever had any problems with your eyes or vision?
☐	☐	10.	Do you wear any dental appliances such as braces, bridge, plate, retainer, etc.?
☐	☐	11.a	Have you ever had a knee injury?
☐	☐	b	Have you ever had an ankle injury?
☐	☐	c	Have you ever injured any other joint (shoulder, wrist, fingers, etc.)?
☐	☐	d	Have you ever broken a bone or had a fracture?
☐	☐	e	Have you ever had a cast, splint, or had to use crutches?
☐	☐	f	Are you required to use special equipment for competition (pads, braces, neck roll, etc.)?
☐	☐	12.	Has it been 5 or more years since your last tetanus shot? If so, when: ______________________
☐	☐	13.	Do you have any worries or concerns regarding your weight?
☐	☐	14.	FEMALES: Have you had any menstrual problems?
☐	☐	15.	Have you had any medical concerns about participating in your sport?

PHYSICAL / WELLNESS EXAMINATION (TO BE FILLED OUT BY PHYSICIAN)

***** EXAMINER, write all comments to questions marked "yes" on the back of this page. Reference question number, Thank you*****

Height _______ **Weight** _______ **Blood Pressure** ________ **Age** ______ **Birth date** ____/____/____

Pulse _______ **Visual acuity: Left 20/**_____ **Right 20/**_____ **Wrestling Weight (min Wt.)**__________

Normal		Normal		Normal		Normal	
☐ 1.	Head	☐ 5.	Lungs	☐ 9.	Neurological	☐ 13.	Shoulders, Upp Ext.
☐ 2.	Eyes (pupils), ENT	☐ 6.	Heart	☐ 10.	Skin	☐ 14.	Lower Extremities
☐ 3.	Teeth	☐ 7.	Abdomen	☐ 11.	Physical Maturity	☐ 15.	Other _________
☐ 4.	Chest	☐ 8.	Genitalia	☐ 12.	Spine, Back	☐ 16.	Other _________

Areas not checked as 'normal' above need to be identified and explanations given:______________________________

Overall Assessment: ☐ **Full Participation** ☐ **Limited Participation (explain)** ______________________________

☐ **Recommendations: (equipment, taping, rehabilitation)** ______________________________

Date: ____/____/____ **Examiner's Signature** ______________________________ **Phone(**____**)**______________

Print Name of Examiner ______________________________