



## Sandpoint Junior Academy Physical Examination Form

**A physical exam is required for all new students. A standard form with release for sports is also acceptable.**

### Part I – Student Information (To be completed by athlete/ parent)

Name: \_\_\_\_\_ School Year: \_\_\_\_\_ Grade: \_\_\_\_\_

I am planning to participate in the following sports/activities: Ski PE & other PE activities

### Part II – Medical History

(This side of the form must be completed by parent and student prior to the time of the physical exam and presented to the health care provider before the physical.)

Check the appropriate response to each item:

Yes: No: If Yes, Please Explain:

- |   | Yes:                     | No:                      |       |
|---|--------------------------|--------------------------|-------|
| 1. Have you ever been hospitalized? .....                                 | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have you ever had surgery of any kind? .....                              | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2. Are you presently taking any medications or pills? .....               | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. Have you ever passed out during exercise? .....                        | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have you ever been dizzy during or after exercise? .....                  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have you ever had chest pain during or after exercise? .....              | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have you ever had high blood pressure? .....                              | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have you ever been told you had a heart murmur? .....                     | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have you ever had racing of your heart? .....                             | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Has anyone in your family died of heart problems before 50? .....         | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4. Do you have any skin problems? (itching, rash, acne) .....             | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 5. Have you ever had a head injury? .....                                 | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have you ever been knocked out or unconscious? .....                      | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have you ever had a seizure or suffered from epilepsy? .....              | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have you ever had a stinger, burner or pinched nerve? .....               | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 6. Have you ever had heat related problems? .....                         | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have you ever been dizzy or passed out in the heat? .....                 | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 7. Do you cough heavily, or breathe heavily during activity? .....        | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 8. Do you use any special equipment (e.g. knee brace)? .....              | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 9. Have you had any problems with your eyes or vision? .....              | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 10. Have you ever sprained/strained, dislocated, fractured, broken, ..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| or had repeated swelling or other injuries of any bones? .....            | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 11. Are you missing one of any paired organs (e.g. eyes) .....            | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 12. Have you ever been diagnosed with any form of asthma? .....           | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Are you using an inhaler for asthma? .....                                | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 13. Are you diabetic? .....   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you administer insulin to yourself? .....                              | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 14. Do you have a history of sickle-cell anemia in your family? .....     | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 15. Have you had any other medical problems? .....                        | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 16. Have you had a medical problem or injury within the last year? .....  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 17. When was your last tetanus shot? .....                                |                          |                          | _____ |
| 18. Do you want to lose or gain weight? .....                             | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you lose weight for your sport? .....                                  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Additional information about any “Yes” answers from questions 1 – 17 \_\_\_\_\_

**Part III – Physical Examination** (To be completed by Health Care Provider)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Pulse: \_\_\_\_\_

	Normal	Abnormal	Comment
<b>Heart:</b>			
Rhythm (Reg/irreg)			
Murmur (supine)			
Murmur (standing)			
<b>ENT:</b>			
<b>Lungs:</b>			
<b>Skin:</b>			
<b>Abdomen:</b>			
<b>Musculoskeletal:</b>			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			
<b>Other:</b>			

I have reviewed the data above, reviewed the student's medical history and make the following recommendations on participation in athletics:

1. Cleared: \_\_\_\_\_
2. Cleared after additional evaluation for: \_\_\_\_\_
3. Restricted from participating in the sports/activities of: \_\_\_\_\_
4. Cleared to participate in the sports/activities of: \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_  
Signature of Health Care Provider Date

\_\_\_\_\_  
Name of Health Care Provider (Please Print)

\_\_\_\_\_  
Address Phone