

Spencer Van Etten School District

Pre-physical Health History

STUDENT: _____ DOB _____ Grade _____

Participation in athletics is voluntary and is not a required part of the regular physical education program.

Sports Activities:

Identify any sports in which you **do not wish** your child to participate:

THIS FORM MUST BE COMPLETED AND RETURNED ONE WEEK BEFORE THE ATHLETE HAS HIS/HER PHYSICAL.

HEALTH HISTORY TO BE COMPLETED BY PARENT

Has your child ever had: (please check)

	YES	NO		YES	NO
Allergies/Hay Fever	<input type="radio"/>	<input type="radio"/>	Elevated Blood Pressure	<input type="radio"/>	<input type="radio"/>
Bee Sting Allergy	<input type="radio"/>	<input type="radio"/>	Injury to Spleen	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	Head Injury/Concussion	<input type="radio"/>	<input type="radio"/>
Anemia	<input type="radio"/>	<input type="radio"/>	Heart Problem/Murmur-Chest pain	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>	Nose Bleeds/Frequent or Severe	<input type="radio"/>	<input type="radio"/>
Bladder/Kidney Problem or Injury	<input type="radio"/>	<input type="radio"/>	Ankle Injury	<input type="radio"/>	<input type="radio"/>
Convulsions/Seizures	<input type="radio"/>	<input type="radio"/>	Back Pain/Injury	<input type="radio"/>	<input type="radio"/>
Fainting Spells	<input type="radio"/>	<input type="radio"/>	Fracture-Dislocation Bones/Joints	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	Knee Pain/Injury	<input type="radio"/>	<input type="radio"/>
Ear Problems/Hearing Loss	<input type="radio"/>	<input type="radio"/>	Neck Injury	<input type="radio"/>	<input type="radio"/>
Eye Problems/Vision Loss	<input type="radio"/>	<input type="radio"/>	Nose Fracture	<input type="radio"/>	<input type="radio"/>
Headaches	<input type="radio"/>	<input type="radio"/>	Rheumatic Fever	<input type="radio"/>	<input type="radio"/>
Joint Sprain/Ligament Tear/Muscle Pullo	<input type="radio"/>	<input type="radio"/>	Stomach Ulcer	<input type="radio"/>	<input type="radio"/>

YES **NO**

Is there a current medical examination (within 1 yr) on file in the nurse's office:

Is your child assigned to the Adaptive Physical Education Program or has he/she been in the Adaptive Physical Education? (a special PE class)

Has your child been unconscious or lost memory from a blow on the head?

Does your child have any of the following:

	YES	NO
One eye or severe uncorrectable loss of vision in one or both eyes.....	<input type="radio"/>	<input type="radio"/>
Severe hearing loss in both ears.....	<input type="radio"/>	<input type="radio"/>
One kidney.....	<input type="radio"/>	<input type="radio"/>
One testicle (males).....	<input type="radio"/>	<input type="radio"/>
Has your child been ill for five (5) consecutive days? If yes, time period.....	<input type="radio"/>	<input type="radio"/>

Has your child ever had an illness, condition, or injury that required him/her to go to the hospital either as a patient overnight or in the emergency room or for x-rays; required an operation; caused your child to miss a game or practice? If yes, time period _____

Is your child under medical care now?.....

Has your child taken any medication in the past year?.....

If so, why? _____

(Continued on back page)

	YES	NO
Is your child taking any medications now?.....	o	o
If so, why?_____		
Has your child ever fainted during exercise?.....	o	o
If so, explain._____		
Has there ever been sudden death in a family member under fifty (50) years of age?.....	o	o

Does your child have: orthodontic appliances?.....	o	o
Capped teeth?.....	o	o
Wear contact lenses for sports?.....	o	o
Wear glasses for sports?.....	o	o
Since your child's last physical examination, has your child had any injury or illnesses?..	o	o
If yes, explain: _____		

I agree with the above answers and consent to participation of my child in the interscholastic program of his/her school including practice sessions and travel to and from the athletic contests.

PARENT/GUARDIAN SIGNATURE: _____ **Date:** _____

FOR SCHOOL PHYSICIAN USE ONLY

This certifies that _____ is physically qualified to participate in the following categories of competition during the school year 20__ to 20__.

Any unmarked categories indicates disqualification from the particular group of sports activities.

CONTACT/COLLISION	LIMITED CONTACT/ IMPACT	STRENUOUS NON-CONTACT	NONSTRENUOUS NON-CONTACT
<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>
Field Hockey Football Wrestling Soccer	Baseball Basketball Softball Volleyball	Track and Field Cross-country	Golf

School Physician's Signature

Date