

## North Kitsap School District #400 Pre-participation History and Physical Examination Form

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Zip: \_\_\_\_\_ Sport(s): \_\_\_\_\_  
 Grade: \_\_\_\_\_ School: \_\_\_\_\_

**PLEASE EXPLAIN ANY YES ANSWERS BELOW!**  
**HISTORY**

- |     | YES                      | NO                       |   |
|-----|--------------------------|--------------------------|---|
| 1.  | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any illness/injury recently, or do you have an illness/injury now?                     |
| 2.  | <input type="checkbox"/> | <input type="checkbox"/> | Have you had a medical problem, illness or injury since your last exam?                             |
| 3.  | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any chronic or recurrent illness?   |
| 4.  | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any illness lasting more than a week?   |
| 5.  | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hospitalized over night?   |
| 6.  | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any surgery other than tonsillectomy?  |
| 7.  | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any injuries requiring treatment by a physician?                                  |
| 8.  | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any organ missing other than tonsils (appendix, eye, kidney, etc.)?                     |
| 9.  | <input type="checkbox"/> | <input type="checkbox"/> | Are you presently taking ANY medications?   |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have ANY allergies (medicines, bees, foods, or other factors)?                               |
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?            |
| 12. | <input type="checkbox"/> | <input type="checkbox"/> | Do you tire more easily or quickly than your friends during exercise?                               |
| 13. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any problem with your blood pressure or your heart?                               |
| 14. | <input type="checkbox"/> | <input type="checkbox"/> | Have any close relatives had heart problems, heart attack, or sudden death before they were age 50? |
| 15. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any skin problems (acne, itching rashes, etc.)?   |
| 16. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had fainting, convulsions, seizures, or severe dizziness?                             |
| 17. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have frequent severe headaches?  |
| 18. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a "stinger" or "burner" or "pinched nerve"?                                       |
| 19. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had been "knocked out" or "passed out"?   |
| 20. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a neck or head injury?  |
| 21. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had heat exhaustion, heat stroke, heat cramps, or similar heat-related problems?      |
| 22. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had asthma, or trouble breathing, or cough during or after exercise?                       |
| 23. | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear eyeglasses, contact lenses, or protective eye wear?                                     |
| 24. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any problem with your eyes or vision?  |
| 25. | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear any dental appliance such as braces, bridge, plate, and retainer?                       |
| 26. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a knee injury?  |
| 27. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an ankle injury?  |
| 28. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever injured any other joint (shoulder, wrist, fingers, etc.)?                             |
| 29. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a broken bone (fracture)?   |
| 30. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a cast, splint, or had to use crutches?   |
| 31. | <input type="checkbox"/> | <input type="checkbox"/> | Must you use special equipment for competition (pads, braces, neck roll, etc.)?                     |
| 32. | <input type="checkbox"/> | <input type="checkbox"/> | Has it been more than 5 years since your last tetanus booster shot?                                 |
| 33. | <input type="checkbox"/> | <input type="checkbox"/> | Are you worried about your weight?  |
| 34. | <input type="checkbox"/> | <input type="checkbox"/> | <b>FEMALES:</b> Have you any menstrual problems?  |
| 35. | <input type="checkbox"/> | <input type="checkbox"/> | Have you any medical concerns about participating in your sport?                                    |

Yes Answers \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PARENT SIGNATURE: \_\_\_\_\_

**PHYSICAL EXAMINATION**

Age: \_\_\_\_\_ Pulse: \_\_\_\_\_  
 Height: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_  
 Weight: \_\_\_\_\_ Visual Acuity: Left 20/\_\_\_\_\_  
 Right 20/\_\_\_\_\_

- |                          | Normal                |                          | Abnormal |       |
|--------------------------|-----------------------|--------------------------|----------|-------|
| <input type="checkbox"/> | 1. Head               | <input type="checkbox"/> | _____    | _____ |
| <input type="checkbox"/> | 2. Eyes (Pupils), ENT | <input type="checkbox"/> | _____    | _____ |
| <input type="checkbox"/> | 3. Teeth              | <input type="checkbox"/> | _____    | _____ |
| <input type="checkbox"/> | 4. Chest              | <input type="checkbox"/> | _____    | _____ |
| <input type="checkbox"/> | 5. Lungs              | <input type="checkbox"/> | _____    | _____ |
| <input type="checkbox"/> | 6. Heart              | <input type="checkbox"/> | _____    | _____ |
| <input type="checkbox"/> | 7. Abdomen            | <input type="checkbox"/> | _____    | _____ |
| <input type="checkbox"/> | 8. Neurologic         | <input type="checkbox"/> | _____    | _____ |
| <input type="checkbox"/> | 9. Skin               | <input type="checkbox"/> | _____    | _____ |
| <input type="checkbox"/> | 10. Physical Maturity | <input type="checkbox"/> | _____    | _____ |
| <input type="checkbox"/> | 11. Spine, Back       | <input type="checkbox"/> | _____    | _____ |
| <input type="checkbox"/> | 12. Upper Extremities | <input type="checkbox"/> | _____    | _____ |
| <input type="checkbox"/> | 13. Lower Extremities | <input type="checkbox"/> | _____    | _____ |
| <input type="checkbox"/> | 14. Flexibility       | <input type="checkbox"/> | _____    | _____ |

**Assessment:**

- Full Participation  
 Limited Participation (describe limitations, restrictions):

\_\_\_\_\_  
 \_\_\_\_\_

- Participation contraindicated (list reasons):

\_\_\_\_\_  
 \_\_\_\_\_

**Recommendations (equipment, taping, rehabilitation, etc.):**

\_\_\_\_\_  
 \_\_\_\_\_

**Will this physical be acceptable for High School Sports: Yes No (Circle one)**

DATE: \_\_\_\_\_ EXAMINER'S PHONE: ( ) \_\_\_\_\_

EXAMINER'S SIGNATURE: \_\_\_\_\_

EXAMINER'S PRINTED NAME: \_\_\_\_\_

**MEDICAL AUTHORITIES LICENSED TO GIVE PREPARTICIPATION PHYSICAL EXAMINATION:**

- 1. Medical Doctor (MD) 2. Doctor of Osteopathy (D.O.) 3. Certified Nurse Practitioner (CRN) 4. Physician Assistant (P.A.) 5. Naturopaths (N.D.)**