PUYALLUP SCHOOL DISTRICT
PARTICIPATION HISTORY FORM

NAME: _____STUDENT ID#_____ BIRTHDATE: _____

GRADE: _____ MALE ❒ FEMALE ❒ DATE COMPLETED: _____

ADDRESS: _____CITY: _____ZIP: _____PHONE:_____

		YES	NO	HISTORY
1.		-------	-------	Do you have any life threatening physical condition? If yes, a yearly school Emergency Action Plan and medical orders signed by a Physician must be attached to this form (see school nurse for forms).
2.	a.	-------	-------	Have you had any illness 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 illness?
	d.	-------	-------	Have you ever had any illness lasting more than a week?
	e.	-------	-------	Have you ever been hospitalized overnight?
	f.	-------	-------	Have you ever had surgery other than a tonsillectomy?
3.		-------	-------	Are you presently taking ANY medication (including birth control pills, vitamins, aspirin, etc.)?
4.		-------	-------	Do you have ANY allergies (medicines, bees, foods or other factors)?
5.	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 your blood pressure or your heart?
	d.	-------	-------	Have any close relatives had heart problems, a heart attack or sudden death before they were age 50?
6.		-------	-------	Do you have any skin problems (acne, itching, rashes)?
7.	a.	-------	-------	Have you ever had fainting, convulsions, seizures or severe dizziness?
	b.	-------	-------	Do you have frequent severe headaches?
	c.	-------	-------	Have you ever had "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?
	f.	-------	-------	Have you ever had a concussion? Date: _____
8.		-------	-------	Have you ever had asthma, or trouble breathing, or cough during or after exercise?
9.	a.	-------	-------	Do you wear eyeglasses, contact lenses or protective eye wear?
	b.	-------	-------	Have you ever had any problem with your eyes or vision?
10.		-------	-------	Do you wear any dental appliance such as braces, a bridge, plate, retainer?
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 had a broken bone (fracture)?
	e.	-------	-------	Have you ever had a cast, splint, or had to use crutches?
	f.	-------	-------	Must you use special equipment for competition (pads, neck braces, neck roll, etc.)?
12.		-------	-------	Has it been more than 5 years since your last tetanus booster shot?
13.		-------	-------	Are you worried about your weight?
14.		-------	-------	FEMALES: Have you had any menstrual problems?
15.		-------	-------	Do you have any medical concerns about participating in your sport?

EXAMINER'S COMMENTS ON ALL "YES" ANSWERS (refer to question number): _____

_____

Student Signature/Date: _____

Parent Signature/Date: _____

PUYALLUP SCHOOL DISTRICT
PHYSICAL EXAMINATION FORM

(NOTE: THIS EXAMINATION IS FOR A PERIOD OF 24 MONTHS PER WIAA REGULATION, UNLESS OTHERWISE INDICATED)

NAME: _____ **AGE:** _____ **HEIGHT:** _____ **WEIGHT:** _____

BLOOD PRESSURE: _____ **PULSE:** _____ **VISUAL ACUITY: L** _____ **R** _____

	Normal		Abnormal	
(1)	_____	**Head**	_____	_____
(2)	_____	**Eyes (pupils), ENT**	_____	_____
(3)	_____	**Teeth**	_____	_____
(4)	_____	**Chest**	_____	_____
(5)	_____	**Lungs**	_____	_____
(6)	_____	**Heart**	_____	_____
(7)	_____	**Abdomen**	_____	_____
(8)	_____	**Genitalia**	_____	_____
(9)	_____	**Neurologic**	_____	_____
(10)	_____	**Skin**	_____	_____
(11)	_____	**Physical Maturity**	_____	_____
(12)	_____	**Spine, Back**	_____	_____
(13)	_____	**Shoulders, Upper Extremities**	_____	_____
(14)	_____	**Lower Extremities**	_____	_____

CIRCLE CONDITIONS THAT MAY AFFECT STUDENT DURING SPORT/ACTIVITY:

ASTHMA DIABETES SEIZURE DISORDER ALLERGY to Bee Sting ALLERGY to Food _____ Other_____

❒ **CHECK HERE IF CHILD'S HEALTH CONDITION IS LIFE THREATENING: (Current Emergency Action Plan Required)**

❒ **CHECK HERE IF STUDENT MUST HAVE ACCESS TO EMERGENCY MEDS: (Current Medication Form Required)**

ASSESSMENT: ❒ ***FULL PARTICIPATION***

❒ ***LIMITED PARTICIPATION (describe limiting restrictions)***

PARTICIPATION CONTRAINDICATED (LIST REASONS):

_____

RECOMMENDATIONS (EQUIPMENT, TAPING, REHABILITATION, ETC.):

_____

PHYSICAL EXAMINATION COMPLETED BY:

PRINT EXAMINER'S NAME: _____ **EXAMINER'S SIGNATURE:** _____

DATE: _____ **EXAMINER'S PHONE:** _____