Hawaii State Department of Education

PHYSICAL EXAMINATION FOR ATHLETES

Student's Name (PRINT) ______ LAST ______ FIRST ______ MIDDLE INITIAL M/F_____ Date of Birth ______ / ______ / ______ MONTH DAY YEAR

Address ______ STREET NO. ______ CITY ______ STATE ______ ZIP CODE Home Telephone ______ Grade ______

School ______ School Telephone ______ FAX No. ______

PHYSICAL EXAMINATION

Height ______ Weight ______ Blood Pressure ______ / ______ Pulse ______

Vision: Right 20/ ______ Left 20/ ______ Corrected: Yes _____ No _____ Pupils ______

Immunization ______

	Normal	Abnormal Findings				Initial
Cardiopulmonary						
Pulses						
Heart						
Lungs						
Abdominal						
E.N.T.						
Skin						
Genitalia						
Tanner stage	1	2	3	4	5	
Musculoskeletal						
Neck						
Shoulder						
Elbow						
Wrist						
Hand						
Back						
Knee						
Ankle						
Foot						
Other						

Clearance:

A. Cleared ______

B. Cleared after completing evaluation/rehabilitation for ______

C. Not cleared for ❑ Collision

❑ Contact

❑ Noncontact ❑ Strenuous ❑ Moderately Strenuous ❑ Nonstrenuous

Due to ______

Physician's Recommendation ______

______

______

Name of Physician ______ Date ______

Address ______ Telephone ______

Signature of Physician ______ FAX No. ______

PRE-PARTICIPATION PHYSICAL EVALUATION FORM
MEDICAL HISTORY DATA

Please explain "Yes" answers below.

		Yes	No
1.	Have you ever been hospitalized?	❑	❑
	Have you ever had surgery?	❑	❑
2.	Are you presently taking any medications or pills?	❑	❑
3.	Do you have any allergies (medicine, bees or other stinging insects)?	❑	❑
4.	Have you ever passed out during or after exercise?	❑	❑
	Have you ever been dizzy during or after exercise?	❑	❑
	Have you ever had chest pains during or after exercise?	❑	❑
	Do you tire more quickly than your friends during exercise?	❑	❑
	Have you ever had high blood pressure?	❑	❑
	Have you ever been told that you have a heart murmur?	❑	❑
	Have you ever had racing of your heart or skipped heartbeats?	❑	❑
	Has anyone in your family died of heart problems or a sudden death before age 50?	❑	❑
5.	Do you have any skin problems (itching, rashes, acne)?	❑	❑
6.	Have you ever had a head injury?	❑	❑
	Have you ever been knocked out or unconscious?	❑	❑
	Have you ever had a seizure?	❑	❑
	Have you ever had a stinger, burner or pinched nerve?	❑	❑
7.	Have you ever had heat or muscle cramps?	❑	❑
	Have you ever been dizzy or passed out in the heat?	❑	❑
8.	Do you have trouble breathing or do you cough during or after activity?	❑	❑
9.	Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?	❑	❑
10.	Have you had any problems with your eyes or vision?	❑	❑
	Do you wear glasses or contacts or protective eye wear?	❑	❑
11.	Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?	❑	❑

❑ Head	❑ Shoulder	❑ Thigh	❑ Neck	❑ Elbow
❑ Knee	❑ Hip	❑ Chest	❑ Forearm	❑ Shin/calf
❑ Back	❑ Wrist	❑ Ankle	❑ Foot	❑ Hand

		Yes	No
12.	Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?	❑	❑
13.	Have you had a medical problem or injury since your last evaluation?	❑	❑
14.	When was your last tetanus shot?	❑	❑
	When was your last measles immunization?	❑	❑
15.	When was your first menstrual period?	❑	❑
	When was your last menstrual period?	❑	❑
	When was the longest time between your periods last year?	❑	❑

Explanation of "Yes" answers:

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____

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I hereby verify to the best of my knowledge that the answers which have been provided to the above questions are correct.

Signature of Student ______________________ Date: ______________

Signature of Parent/Guardian ______________________ Date: ______________

Note: Please return this form to the Athletic Director after the physician has reviewed and completed the evaluation.