

BELLEVUE SCHOOL DISTRICT
HIGH SCHOOL MEDICAL HISTORY AND PHYSICAL EXAMINATION
AND ATHLETICS ELIGIBILITY REPORT

Name: _____ Birth Date: _____ Year of Graduation: _____ M ___ F ___

Parent/guardian name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ School: _____ Date of Exam: _____ Student # _____

Sport(s): (List all): _____

MEDICAL HISTORY

- | | Yes | No | (Please explain all yes answers) |
|-----|--------------------------|--------------------------|---|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Are you presently taking any medication? List: _____
-- What is the medication taken for? _____ |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any chronic or recurrent medical conditions? _____ |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any surgeries? _____ |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any missing organs other than tonsils (appendix, eye, kidney, etc.)? _____ |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any allergies/conditions that are life threatening* or affect school/sports? _____ |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had chest pain, dizziness, fainting, passing out during or after exercise? _____ |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any problems with your blood pressure or heart? _____ |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any skin problems? _____ |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had fainting, convulsions, seizures, or severe dizziness? _____ |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had asthma or trouble breathing or a cough during exercise? _____ |
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear corrective lenses or protective eye wear? _____ |
| 12. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have a significant vision or hearing problem? _____ |
| 13. | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear any dental appliances such as braces, bridge, plate, retainer? _____ |
| 14. | <input type="checkbox"/> | <input type="checkbox"/> | FEMALES: Have you had any menstrual problems? _____ |
| 15. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any other medical concerns? _____ |

* WAC 180-38-045 Attendance of every student at every public school who has a LIFE THREATENING health condition is

conditioned upon parent presentation of a medication/treatment order, formulation of a nursing plan to implement the order.

SPORTS/INJURY HISTORY

- | | | | |
|-----|--------------------------|--------------------------|--|
| 16. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any medical concerns about participating in your sport? _____ |
| 17. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any injuries requiring treatment by a physician? _____ |
| 18. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a knee injury? _____ |
| 19. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an ankle injury? _____ |
| 20. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a broken bone (fracture)? _____ |
| 21. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever injured any other joint (shoulder, wrist, fingers, etc)? _____ |
| 22. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a cast, splint, or had to use crutches? _____ |
| 23. | <input type="checkbox"/> | <input type="checkbox"/> | Must you use special equipment for competition (pads, braces, neck roll, etc)? _____ |
| 24. | <input type="checkbox"/> | <input type="checkbox"/> | Has it been more than 5 years since your last tetanus booster shot? _____ |
| 25. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a neck/head injury? _____ When? _____ |
| 26. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a heat related problem? (Heat exhaustion, heat stroke) _____ |

Parents/Students: DO NOT WRITE BELOW THIS LINE

EXAMINER'S COMMENT ON ALL "YES" ANSWERS (refer to number):
