

**Physical Examination**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_  
 Pulse resting \_\_\_\_\_ after 2 minutes \_\_\_\_\_  
 Visual Acuity: Eyes (R) 20/ \_\_\_\_\_ (L) 20/ \_\_\_\_\_ w/ glasses \_\_\_\_\_ w/o glasses \_\_\_\_\_

Other Testing	Normal	Abnormal Findings
1. General	_____	_____
2. Skin	_____	_____
3. HEENT	_____	_____
4. Teeth (Dental Exam)	_____	_____
5. Neck	_____	_____
6. Lungs	_____	_____
7. Heart (Sit and Stand)	_____	_____
8. Abdomen	_____	_____
9. Genitalia	_____	_____
10. Musculoskeletal	_____	_____
Neck	_____	_____
Shoulder/Arm	_____	_____
Elbow/Forearm	_____	_____
Wrist/Hand	_____	_____
Back	_____	_____
Hip/Thigh	_____	_____
Knee	_____	_____
Shin/Calf	_____	_____
Ankle/Leg	_____	_____
Foot	_____	_____

11. Peripheral Pulses \_\_\_\_\_ U/V \_\_\_\_\_ EKG \_\_\_\_\_  
 12. Neurologic \_\_\_\_\_ % Body Fat \_\_\_\_\_ Drug Screen \_\_\_\_\_ Chest X-Ray \_\_\_\_\_  
 13. Mental Status \_\_\_\_\_ S/MAC \_\_\_\_\_ Tanner Stage \_\_\_\_\_  
 14. Marfan Screen \_\_\_\_\_

On the basis of the examination on this day, I approve this child's participation in interscholastic sports for one year.  
 Yes \_\_\_\_\_ No \_\_\_\_\_ Limited \_\_\_\_\_

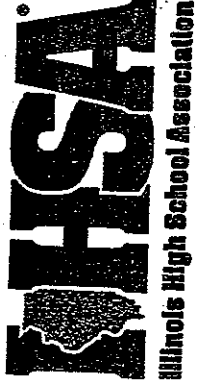
Additional Comments: \_\_\_\_\_

Examination Date \_\_\_\_\_ Physicians Signature \_\_\_\_\_  
 Physician's Assistant Signature\* \_\_\_\_\_  
 Advanced Nurse Practitioner Signature\* \_\_\_\_\_

\* effective January 2003, the HSA Board of Directors approved a recommendation, consistent with the Illinois School Code, that allows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.

STUDENT'S NAME \_\_\_\_\_

SCHOOL NAME \_\_\_\_\_



**Consent Form to self administer asthma medication**  
 (not needed if current form is already on file with school)

**Parent Consent**

I, \_\_\_\_\_ do hereby give my son/daughter, \_\_\_\_\_ permission to self-administer his/her asthma medication as prescribed by his/her physician during athletic competition.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**Physician Consent**

As a patient under my care, \_\_\_\_\_ is prescribed to self-administer the following asthma medication.

Medication \_\_\_\_\_

Purpose \_\_\_\_\_

Dosage \_\_\_\_\_

Time/Special Circumstances \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

# WISA Preparticipation Examination

To be completed by athlete or parent

Name \_\_\_\_\_  
 Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Sport/Position \_\_\_\_\_  
 Social Security Number \_\_\_\_\_ School Year \_\_\_\_\_  
 Address \_\_\_\_\_  
 City/State \_\_\_\_\_ Phone No. \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Class \_\_\_\_\_ Student ID No. \_\_\_\_\_  
 Parent's Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone No. \_\_\_\_\_  
 Person to contact in case of emergency \_\_\_\_\_ City/State \_\_\_\_\_  
 Phone No. \_\_\_\_\_  
 Family Doctor \_\_\_\_\_  
 Phone No. \_\_\_\_\_

## Past Medical History

- |  | Yes   | No    | If yes, please explain (what, where, when) |
|--|-------|-------|--|
| 1. Presently taking medication (including birth control pills)?  | _____ | _____ | _____                                      |
| 2. Have you been diagnosed with asthma?  | _____ | _____ | _____                                      |
| 3. Have you been prescribed by a physician to use any asthma medication?   | _____ | _____ | _____                                      |
| 4. Do you have a current consent form to self-administer the asthma medication on file with your school?                     | _____ | _____ | _____                                      |
| 5. Allergic to medicine, foods, bee stings?  | _____ | _____ | _____                                      |
| 6. Wears any appliances—glasses, contact lenses?   | _____ | _____ | _____                                      |
| 7. History of braces, chipped teeth, bridges?  | _____ | _____ | _____                                      |
| 8. Has ongoing medical problem?  | _____ | _____ | _____                                      |
| 9. Had serious or significant illness in past?   | _____ | _____ | _____                                      |
| 10. Any past surgical operations, accidents, non-sports or related injuries?   | _____ | _____ | _____                                      |
| 11. Any past injuries directly related to sports?  | _____ | _____ | _____                                      |
| 12. Any hospitalization not explained above?   | _____ | _____ | _____                                      |
| 13. Any known deformities (such as curvature of back, heart problems, one kidney, blindness in one eye, one testicle, etc.)? | _____ | _____ | _____                                      |
| 14. Any serious family illness (such as diabetes, bleeding disorders, etc.)?   | _____ | _____ | _____                                      |
| 15. Heart?   | _____ | _____ | _____                                      |
| Have you ever passed out during or after exercise?   | _____ | _____ | _____                                      |
| Have you ever been dizzy during or after exercise?   | _____ | _____ | _____                                      |
| Have you ever had chest pain during or after exercise?   | _____ | _____ | _____                                      |
| Do you get tired more quickly than your friends do during exercise?  | _____ | _____ | _____                                      |
| Have you ever had racing of your heart or skipped heartbeats?  | _____ | _____ | _____                                      |

Yes No  
 If yes, please explain (what, where, when)

- Have you had high blood pressure or high cholesterol? \_\_\_\_\_  
 Have you ever been told you have a heart murmur? \_\_\_\_\_  
 Has any family member or relative died of heart problems or of sudden death before age 50? \_\_\_\_\_  
 Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month? \_\_\_\_\_  
 Has a physician ever denied or restricted your participation in sports for any heart problems? \_\_\_\_\_  
 Has anyone in your family had a heart attack before the age of 50? \_\_\_\_\_
16. Head and Nerve  
 Have you ever had a head injury or concussion? \_\_\_\_\_  
 Have you ever been knocked out, become unconscious, or lost your memory? \_\_\_\_\_  
 Have you ever had a seizure? \_\_\_\_\_  
 Do you have frequent or severe headaches? \_\_\_\_\_  
 Have you ever had numbness or tingling in your arms, hands, legs or feet? \_\_\_\_\_  
 Have you ever had a stinger, burner or pinched nerve? \_\_\_\_\_  
 Last tetanus shot? \_\_\_\_\_ Date \_\_\_\_\_  
 Last eye exam? \_\_\_\_\_ Date \_\_\_\_\_  
 Last menstrual period (if women) \_\_\_\_\_ Date \_\_\_\_\_

## Personal Habits

- Smoking/smokeless tobacco \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_
- Alcohol/non-medical drugs: marijuana, cocaine, etc \_\_\_\_\_
- Steroids \_\_\_\_\_
- Eating Disorders - weight loss or gain? \_\_\_\_\_

Review of systems (Please check if you have any problems with any of the following areas of your body)

Skin _____	Lungs _____	Shoulders, Arms, _____
Head _____	Heart _____	Hands _____
Eyes _____	Abdomen _____	Wips, Legs, Feet _____
Ears _____	Back _____	Muscles—Strength, _____
Nose _____	Urination, _____	Feeling _____
Mouth/Throat _____	Bowel Control _____	Mental, Emotional _____
Nutrition, _____	Genital (including _____	Fatigue _____
Weight Control _____	menstrual for women) _____	Other: What? _____
Neck _____		

I certify that the above information is correct to the best of my knowledge.

Student Signature \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

**Both Student And Parent/Guardian Signatures Are Mandatory**