

# Hawaii State Department of Education

## PHYSICAL EXAMINATION FOR ATHLETES

Student's Name \_\_\_\_\_ M/F \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade \_\_\_\_\_  
 (Print) Last First MI Month Day Year  
 Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Student Resides With \_\_\_\_\_  
 Street No. City State Zip Code  
 Fall Sport \_\_\_\_\_ Winter Sport \_\_\_\_\_ Spring Sport \_\_\_\_\_

Father's/Guardian's Name \_\_\_\_\_ Bus. Phone \_\_\_\_\_ Cell or Pager \_\_\_\_\_  
 Mother's/Guardian's Name \_\_\_\_\_ Bus. Phone \_\_\_\_\_ Cell or Pager \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Bus. Phone \_\_\_\_\_ Cell or Pager \_\_\_\_\_  
 Name & Relationship \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Bus. Phone \_\_\_\_\_ Cell or Pager \_\_\_\_\_  
 Name & Relationship \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Bus. Phone \_\_\_\_\_ Cell or Pager \_\_\_\_\_  
 Name & Relationship \_\_\_\_\_  
 Health and/or Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

The student and parent/guardian consent and authorize school officials through an Athletic Health Care Trainer (AHCT), qualified coach/staff, or physician as determined by the school, to provide any first aid and/or emergency care as well as follow-up first aid or medical treatment that may be reasonably necessary for the student as determined by a school official in the course of athletic practice, competition or travel.

The student and parent/guardian further consent and authorize the school's AHCT to provide appropriate therapeutic modalities in order to return student to athletic competition, such care to be conducted under the direction of a physician.

The student and parent/guardian further consent and authorize the school's AHCT to administer baseline and/or post injury concussion management assessment in order to manage a concussion or suspected head trauma, such care to be conducted under the direction of a physician.

The student and parent/guardian hereby consent to the release of medical information by physician to school to obtain information regarding the medical history, records of injury or surgery, serious illness, and rehabilitation results of the student from his/her physician(s). We understand that the purpose of this request for medical information is to assist the school in the management or rehabilitation of an injury/illness. This information is confidential and except as provided in this release will not be otherwise released by the parties in charge of the information. This release remains valid until revoked by the adult student or parent/guardian in writing.

Signature of Student \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_  
 (parent/guardian fill out back side of this form)

### To be completed by Physician only

Height \_\_\_\_\_ feet & inches Weight \_\_\_\_\_ lbs Blood Pressure \_\_\_\_/\_\_\_\_ Pulse \_\_\_\_\_ bpm  
 Vision: R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected: Yes No Pupils: Equal \_\_\_\_ Unequal \_\_\_\_  
 Asthma \_\_\_\_\_ (Medication Used) Diabetes \_\_\_\_\_ (Medication Used) Allergies \_\_\_\_\_ (Medication Used)

| MEDICAL                | NORMAL | COMMENTS | INITIALS |
|------------------------|--------|----------|----------|
| Appearance             |        |          |          |
| Eyes/ears/nose/throat  |        |          |          |
| Hearing                |        |          |          |
| Lymph nodes            |        |          |          |
| Heart/Murmurs          |        |          |          |
| Pulses                 |        |          |          |
| Lungs                  |        |          |          |
| Abdomen                |        |          |          |
| Skin                   |        |          |          |
| Genitalia              |        |          |          |
| <b>MUSCULOSKELETAL</b> |        |          |          |
| Neck                   |        |          |          |
| Back/Spine             |        |          |          |
| Shoulder/arm           |        |          |          |
| Elbow/forearm          |        |          |          |
| Wrist/hand/fingers     |        |          |          |
| Hip/thigh              |        |          |          |
| Knee                   |        |          |          |
| Calf/ankle             |        |          |          |
| Foot/toes              |        |          |          |
| Other                  |        |          |          |

(Over)

# **Parent/Guardian and Student to fill out before Physical Examination**

Explain "Yes" answers below. Circle question you don't know the answer to.

|                                                                                                                                                                                               | Yes                      | No                       |                                                                                                                   | Yes                      | No                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason?                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> | 25. Do you cough, wheeze or have difficulty breathing during or after exercise?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an ongoing medical condition (like diabetes or asthma)?                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> | 26. Have you ever used an inhaler or taken asthma medicine?                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription (over the counter) medicines or pills?                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> | 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have allergies to medicines, pollens, foods or stinging insects?                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | 28. Have you had infectious mononucleosis (mono) within the last month?                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out or nearly passed out DURING exercise?                                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> | 29. Do you have any rashes, pressure sores, or other skin problems?                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever passed out or nearly passed out AFTER exercise?                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> | 30. Have you had a herpes skin infection?                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had discomfort, pain or pressure in your chest during exercise?                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> | 31. Have you ever had a head injury or concussion?                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does your heart race or skip beats during exercise?                                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> | 32. Have you been hit in the head and been confused or lost your memory?                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has a doctor ever told you that you have: (circle all that apply)<br>High blood pressure      A heart murmur<br>High Cholesterol      A heart infection                                    | <input type="checkbox"/> | <input type="checkbox"/> | 33. Have you ever had a seizure?                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> | 34. Do you have headaches with exercise?                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has anyone in your family died for no apparent reason?                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?            | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does anyone in your family have a heart problem?                                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> | 36. Have you ever been unable to move your arms or legs after being hit or falling?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has any family member or relative died of heart problems or of sudden death before age 50?                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> | 37. When exercising in the heat, do you have severe muscle cramps, or become ill?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Has a family member died while exercising?                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> | 38. Do you have any hearing problems?                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Does anyone in your family have Marfan Syndrome?                                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> | 39. Do you have a hearing device?                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever spent the night in a hospital?                                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> | 40. Do you have a family member with hearing problems?                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had surgery?                                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> | 41. Has a doctor told you that you, or does someone in your family have sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever had an injury, like sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, list affected area: _____                           | <input type="checkbox"/> | <input type="checkbox"/> | 42. Have you had any problems with your eyes or vision?                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you had any broken or fractured bones or dislocated joints? If yes, list affected area: _____                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> | 43. Do you wear glasses or contact lenses?                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, list affected area: _____ | <input type="checkbox"/> | <input type="checkbox"/> | 44. Do you wear protective eyewear, such as goggles or a face shield?                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you ever had a stress fracture?                                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> | 45. Are you happy with your weight?                                                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> | 46. Would you like to lose weight?                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you regularly use a brace or assistive device?                                                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> | 47. Would you like to gain weight?                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Has a doctor ever told you that you have asthma or wheezing?                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> | 48. Has anyone recommended you change your weight or eating habits?                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>EXPLAIN "YES" answers here:</b><br><b>(Add additional pages if necessary)</b>                                                                                                              |                          |                          | 49. Do you limit or carefully control what you eat?                                                               | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                               |                          |                          | 50. Do you have any concerns that you would like to discuss with a doctor?                                        | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                               |                          |                          | 51. Do you feel depressed?                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                               |                          |                          | 52. Do you have a history of multiple or long nosebleeds?                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                               |                          |                          | 53. <b>MALES ONLY:</b> Do you ever have or had swelling of your testicles or groin?                               | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                               |                          |                          | <b>FEMALES ONLY</b>                                                                                               |                          |                          |
|                                                                                                                                                                                               |                          |                          | 54. Have you ever had a menstrual period?                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                               |                          |                          | 55. How many periods have you had in the last 12 months?                                                          | _____                    |                          |

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 \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Clearance: (Place a check in appropriate box below)

- ☐ Cleared for all sports  
☐ Cleared after completing evaluation/rehabilitation for \_\_\_\_\_  
☐ Not cleared for:
 ☐ Collision (Football)
 ☐ Contact (Baseball, Basketball, Cheerleading, Judo, Softball, Soccer, Volleyball, Wrestling)
 ☐ Non contact
 ☐ Strenuous
 ☐ Moderately Strenuous
 ☐ Non-strenuous

Reason not cleared: \_\_\_\_\_

**Physician's Recommendation** \_\_\_\_\_

**Name of Physician** \_\_\_\_\_ **Date of Physical Exam** \_\_\_\_\_

**Address** \_\_\_\_\_ **Telephone** \_\_\_\_\_

**Signature of Physician** \_\_\_\_\_ **Fax Number** \_\_\_\_\_