

**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 <b>any</b> medication? List: _____<br>-- 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 surgery? _____  |
| 4 <input type="checkbox"/>  | <input type="checkbox"/> | Do you have any missing organs other than tonsils (appendix, eye, kidney, testicle, etc.)? _____           |
| 5 <input type="checkbox"/>  | <input type="checkbox"/> | Do you have any <b>allergies/conditions that are life threatening*</b> 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 problem 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 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 appliance 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 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):

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NAME: \_\_\_\_\_

**PHYSICAL EXAMINATION**

Age: \_\_\_\_\_ Pulse: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Visual Acuity: Left:20/\_\_\_\_ Right: 20/\_\_\_\_

Normal    Abnormal

- Head \_\_\_\_\_
- Eyes (pupils) ENT \_\_\_\_\_
- Teeth \_\_\_\_\_
- Chest \_\_\_\_\_
- Lungs \_\_\_\_\_
- Heart \_\_\_\_\_
- Abdomen \_\_\_\_\_
- Genitalia \_\_\_\_\_
- Neurological \_\_\_\_\_
- Skin \_\_\_\_\_
- Physical Maturity \_\_\_\_\_
- Spine, Back \_\_\_\_\_
- Shoulders, upper extremities \_\_\_\_\_
- Lower extremities \_\_\_\_\_

Assessment:

- Full participation
- Limited participation (describe limitations, restrictions):

\_\_\_\_\_  
\_\_\_\_\_

- Participation contraindicated (list reasons):

\_\_\_\_\_  
\_\_\_\_\_

Recommendations (equipment, taping, rehabilitation, etc.) \_\_\_\_\_

DATE: \_\_\_\_\_ EXAMINER'S SIGNATURE: \_\_\_\_\_

Please Print or Stamp:

Name:
Address:
Phone:

Physical examinations are required by WIAA every two years.