**LAWTON ACADEMY OF ARTS & SCIENCES PHYSICAL EXAMINATION AND PARENTAL CONSENT FORM**

PLEASE PRINT DATE OF EXAM\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex \_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Archery Cross Country/Running Club Tennis Soccer

Grade \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sports (Circle all in which student plans to participate) Wrestling Volleyball PE & School-related Physical Activities

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency, contact: Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Explain “Yes” answers on a separate sheet. Circle questions you don’t know the answers to.

1. Have you had a medical illness or injury since your last check up or sports physical? \_\_ YES \_\_ NO
2. Do you have an ongoing or chronic illness? \_\_ YES \_\_ NO
3. Have you ever been hospitalized overnight? \_\_ YES \_\_ NO Have you ever had surgery? \_\_ YES \_\_ NO
4. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? \_\_ YES \_\_ NO
5. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? \_\_ YES \_\_ NO
6. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? \_\_ YES \_\_ NO
7. Have you ever had a rash or hives develop during or after exercise? \_\_ YES \_\_ NO
8. Have you ever passed out during or after exercise? \_\_ YES \_\_ NO
9. Have you ever been dizzy during or after exercise? \_\_ YES \_\_ NO
10. Have you ever had chest pain during or after exercise? \_\_ YES \_\_ NO
11. Do you get tired more quickly than your friends do during exercise? \_\_ YES \_\_ NO
12. Have you ever had racing of your heart or skipped heartbeats? \_\_ YES \_\_ NO
13. Have you had high blood pressure or high cholesterol? \_\_ YES \_\_ NO
14. Have you ever been told you have a heart murmur? \_\_ YES \_\_ NO
15. Has any family member or relative died of heart problems or of sudden death before age 50? \_\_ YES \_\_ NO
16. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? \_\_ YES \_\_ NO
17. Has a physician ever denied or restricted your participation in sports for any heart problems? \_\_ YES \_\_ NO
18. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? \_\_ YES \_\_ NO
19. Have you ever had a head injury or concussion? \_\_ YES \_\_ NO
20. Have you ever been knocked out, become unconscious, or lost your memory? \_\_ YES \_\_ NO
21. Have you ever had a seizure? \_\_ YES \_\_ NO
22. Do you have frequent or severe headaches? \_\_ YES \_\_ NO
23. Have you ever had numbness or tingling in your arms, hands, legs, or feet? \_\_ YES \_\_ NO
24. Have you ever become ill from exercising in the heat? \_\_ YES \_\_ NO
25. Do you cough, wheeze, or have trouble breathing during or after activity? \_\_ YES \_\_ NO
26. Do you have asthma? \_\_ YES \_\_ NO
27. Do you have seasonal allergies that require medical treatment? \_\_ YES \_\_ NO
28. Do you or does someone in your family have sickle cell trait or disease? \_\_ YES \_\_ NO
29. Do you use any special protective or corrective equipment or devices that aren’t usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? \_\_ YES \_\_ NO
30. Have you had any problems with your eyes or vision? \_\_ YES \_\_ NO
31. Do you wear glasses, contacts, or protective eyewear? \_\_ YES \_\_ NO
32. Have you ever had a sprain, strain, or swelling after injury? \_\_ YES \_\_ NO
33. Have you broken or fractured any bones or dislocated any joints? \_\_ YES \_\_ NO
34. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? \_\_ YES \_\_ NO If yes, circle and explain on separate sheet.

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

1. Do you want to weigh more or less than you do now? \_\_ YES \_\_ NO
2. Do you lose weight regularly to meet weight requirements for your sport? \_\_ YES \_\_ NO
3. Do you feel stressed out? \_\_ YES \_\_ NO
4. Record the dates of your most recent immunizations for: Tetanus \_\_\_\_\_\_ Measles \_\_\_\_\_\_\_ Hepatitis \_\_\_\_\_\_\_ Chickenpox\_\_\_\_\_\_\_

The above information is correct to the best of my knowledge. I hereby give my informed consent for the above-mentioned student to participate in activities. I understand the risk of injury in athletic participation. If my son/daughter becomes ill or is injured, necessary medical care can be instituted by physicians, coaches, trainers or other personnel properly trained. I further acknowledge and consent that, as a condition for participating in activities, identifying information about the above-mentioned student may be disclosed to appropriate sports associations in connection with any investigation or inquiry concerning the student’s eligibility to participate and/or any possible violation of that association’s rules. Lawton Academy will undertake reasonable measure to maintain the confidentiality of such identifying information, provided that such information has not otherwise been publicly disclosed in some manner.

Signature of parent/guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Athlete\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_

# PRE-PARTICIPATION PHYSICAL EVALUATION

PLEASE PRINT DATE OF EXAM \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height \_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_ Body fat (optional) \_\_\_\_\_% Pulse\_\_\_\_\_\_\_ BP \_\_\_\_\_\_\_/\_\_\_\_\_\_\_

Vision: R 20/\_\_\_\_\_\_\_ L 20/\_\_\_\_\_\_\_\_ Corrected Y / N Pupils: Equal \_\_\_\_\_\_ Unequal \_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| MEDICAL | NORMAL | ABNORMAL FINDINGS |
| Appearance |  |  |
| Eyes/Ears/Throat |  |  |
| Lymph Nodes |  |  |
| Heart |  |  |
| Pulse |  |  |
| Lungs |  |  |
| Abdomen |  |  |
| Genitalia (male only) |  |  |
| Skin |  |  |
| MUSCULOSKELETAL |  |  |
| Neck |  |  |
| Back |  |  |
| Shoulder/Arm |  |  |
| Elbow/Forearm |  |  |
| Wrist/Hand |  |  |
| Hip/Thigh |  |  |
| Knee |  |  |
| Leg/Ankle |  |  |
| Foot |  |  |

CLEARANCE

( ) Cleared

( ) Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

( ) Not cleared for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recommendations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name & Title of Examiner (Print/Type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Examiner \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_