

**WYOMING HIGH SCHOOL ACTIVITIES ASSOCIATION**  
**SWCSD#2 ACTIVITIES PHYSICAL EXAMINATION FORM AND MEDICAL RECORD**  
**PHYSICIANS STATEMENT MUST BE DATED AFTER MAY 1 TO BE VALID FOR THE UPCOMING SCHOOL YEAR**

Name _____	Sex _____	Age _____	Date of Birth _____
Grade _____	School _____	Sport(s) _____	Phone _____
Address _____			
Personal Physician _____			
<b>In case of emergency, contact</b>			
Name _____	Relationship _____	Phone (H or C) _____	(W) _____

**Explain "Yes" answers below. Circle questions you don't know the answers to.**

		<b>Yes</b>	<b>No</b>			<b>Yes</b>	<b>No</b>
1. Have you had a medical illness or injury since your last check up or sports physical?		<input type="checkbox"/>	<input type="checkbox"/>	10. 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)?		<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized overnight?		<input type="checkbox"/>	<input type="checkbox"/>	11. Have you had any problems with your eyes or vision? Do you wear glasses, contacts, or protective eyewear?		<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription of nonprescription (over-the-counter) medications or pills or using an inhaler?		<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had a sprain, strain, or swelling after injury?		<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?		<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?		<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out during or after exercise?		<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?		<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy during or after exercise?		<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, check appropriate box and explain below</i>			
Have you ever had chest pain during or after exercise?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head		<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
Do you get tired more quickly than your friends do during exercise?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh	
Have you ever had racing of your heart or skipped heartbeats?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee	
Have you had high blood pressure or high cholesterol?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/calf	
Have you ever been told you have a heart murmur?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle	
Has any family member or relative died of heart problems or of sudden death before age 50?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot		
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?		<input type="checkbox"/>	<input type="checkbox"/>	13. Do you want to weigh more or less than you do now?		<input type="checkbox"/>	<input type="checkbox"/>
Has a physician ever denied or restricted your participation in sports for any heart problems?		<input type="checkbox"/>	<input type="checkbox"/>	Do you lose weight regularly to meet weight requirements for your sport?		<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?		<input type="checkbox"/>	<input type="checkbox"/>	14. Do you feel stressed out?		<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had a head injury or concussion?		<input type="checkbox"/>	<input type="checkbox"/>	15. Record the dates of your most recent immunizations (shots) for:			
Have you ever been knocked out, become unconscious, or lost your memory?		<input type="checkbox"/>	<input type="checkbox"/>	Tetanus _____ Measles _____			
Have you ever had a seizure?		<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B _____ Chickenpox _____			
Do you have frequent or severe headaches?		<input type="checkbox"/>	<input type="checkbox"/>	<b>FEMALES ONLY</b>			
Have you ever had numbness or tingling in your arms, hands, legs, or feet?		<input type="checkbox"/>	<input type="checkbox"/>	16. When was your first menstrual period? _____			
Have you ever had a stinger, burner, or pinched nerve?		<input type="checkbox"/>	<input type="checkbox"/>	When was your most recent menstrual period? _____			
8. Have you ever become ill from exercising in the heat?		<input type="checkbox"/>	<input type="checkbox"/>	How much time do you usually have from the start of one period to the start of another? _____			
9. Do you cough, wheeze, or have trouble breathing during or after activity?		<input type="checkbox"/>	<input type="checkbox"/>	How many periods have you had in the last year? _____			
Do you have asthma?		<input type="checkbox"/>	<input type="checkbox"/>	What was the longest time between periods in the last year? _____			
Do you have seasonal allergies that require medical treatment?		<input type="checkbox"/>	<input type="checkbox"/>	<b>Explain "Yes" answers here:</b> _____			
				_____			
				_____			
				_____			
				_____			

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

<b>Signature of athlete</b> _____	<b>Signature of parent/guardian</b> _____	<b>Date</b> _____
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**PARENT/GUARDIAN CONSENT FOR EMERGENCY MEDICAL ASSISTANCE:**

I hereby authorize Sweetwater County School District #2 and its staff members in charge of my child named below to obtain all necessary medical care for my child in the event that I cannot be reached to authorize it myself. I hereby authorize any licensed physician and/or medical personnel to render necessary medical treatment to my child.

<b>Student's Name</b> _____	<b>Father Name and Phone</b> _____
<b>Address</b> _____	<b>Mother Name and Phone</b> _____

\*Sweetwater County School District #2 **DOES NOT** provide medical health insurance benefits for students who choose to participate in school sponsored activities programs. Medical Insurance must be provided in order for the student to participate. For those students who have no medical insurance, the School District can provide information on an affordable and seasonal insurance option. **Please provide your health insurance information below:**

<b>INSURANCE INFORMATION:</b> Company _____	Policy # _____
Insured Person _____	

Signature acknowledges that we have read and understand the above warning, we have provided health insurance information, and we give consent for emergency assistance that might be needed.

<b>Date</b> _____	<b>Signature of Parent/Guardian</b> _____
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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 _____

	*NORMAL*	ABNORMAL FINDINGS
<b>MEDICAL</b>		
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
<b>MUSCULOSKELETAL</b>		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand		
Hip/thigh		
Knee		
Leg/ankle		
Foot		

*\*Normal indicated by check or N\**

Cleared

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

Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_  
 Recommendations: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**\*IF THESE BOXES ARE CHECKED, A COPY OF THIS FORM NEEDS TO BE SENT TO THE APPROPRIATE SCHOOL DISTRICT**

Name of Physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
**Signature of Physician \_\_\_\_\_, MD or DO**

**STUDENT/PARENT/GUARDIAN INFORMED CONSENT**

Participation in all activities requires the acceptance of risk of possible serious injury or illness. The risk can be minimized by following your coaches' rules and procedures, by familiarizing yourself with the rules and guidelines of the activity-including sanitization and cleaning protocols, and by following the specific rules issued by manufacturers for the safe use of your activity equipment. The risk is always there, but you can help minimize it by making safety a shared responsibility. When you make the decision to participate in an activity, you are assuming the shared responsibility of following the activities rules and guidelines, the coaches' rules and processes, all sanitization and cleaning protocols, and the equipment manufacturer's rules. You, as a participant, can help make the activity safer by keeping personal equipment sanitized and clean and not intentionally using techniques which are illegal and which can cause serious injury.

Your signature below indicates that you have been informed about the importance of following rules, guidelines, and protocols in activities participation; and you realize that there is a risk of being injured or becoming ill that is inherent in all activities. You realize that the risk of injury or illness may be severe, including the risk of fractures, brain injuries, paralysis, serious illness, or even death.

Activity programs specifically excluded: \_\_\_\_\_

Date \_\_\_\_\_ Signature of Student-Participant \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_