Hopi Health Care Center
PO Box 4000
Polacca, AZ 86042-4000

First Mesa Elementary School
390 Main Street
Polacca, Arizona 86042

Annual Participation Physical Examination

Name: DOB: / / Date:

Height: Weight: Pulse: Blood Pressure: /

Vision R: 20/ L: 20/ Glasses/Contacts: Yes [ ] No [ ] Pupils: Equal Unequal

	Normal	Abnormal Findings	Initials
Medical			
Appearance			
Skin			
Eyes/Ears/Nose			
Throat/Oropharynx			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia/Hernia			
Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Other studies/evaluations/comments (if applicable):

Immunizations up to date: Yes [ ] No [ ] (Please attach copy of immunization record)

CLEARANCE

[ ] Cleared

[ ] Cleared after completing evaluation/rehabilitation for: ______________________

[ ] Not cleared for: ______________________ Reason: ______________________

Recommendations: ______________________

Name of Physician (print): ______________________ Date: ______________

Address: ______________________ Phone: ______________

Signature of Physician: MD / DO / NP / PA

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Name: Sex: M F Age: DOB: / / Date:

Address: Phone:

In case of emergency, contact: Phone (H): Phone (W):

Explain YES answers below. Circle questions you don't know the answer to.

	YES	NO
Have you had a medical illness or injury since your last check-up or sports physical?		
Do you have an ongoing or chronic illness?		
Are you currently being treated for an injury or condition?		
Have you ever been hospitalized overnight? Have you ever had surgery? If so, list:		
Are you currently taking any prescription or nonprescription medications or using an inhaler? If so, list:		
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?		
Do you have any allergies to medications? Pollen? Food? Pets? Insects?		
Have you ever had a rash or hives develop during or after exercise?		
Have you ever passed out during or after exercise?		
Have you 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 during exercise?		
Have you ever had racing of your heart or skipped heartbeats?		
Have you ever been told you have a heart murmur?		
Have you ever had high blood pressure of high cholesterol?		
Have you had a severe viral infection (ie: mononucleosis or myocarditis) within the last month?		
Has a doctor ever denied or restricted your participation in sports for any heart problems?		
Has anyone in your immediate family had the following conditions: [ ]Diabetes [ ]Heart Disease [ ]High Blood Pressure [ ]Sudden death prior to age 50 [ ]Other:		
Do you have any current skin problems (ie: itching, rashes, acne, warts, fungus, or blisters)?		
Have you ever had a head injury on 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?		
Have you ever become ill when exercising in the heat?		
Do you cough, wheeze, or have trouble breathing during or after activity?		
Do you have asthma?		
Do you use an inhaler?		
Do you have season allergies that require medical treatment?		
Do you use any special protective or corrective equipment or devices that aren't usually used for your sport of position (ie: knee brace, special neck roll, orthotics, retainer for your teeth, hearing aid)?		
Have you had any problems with your eyes or vision?		
Do you wear glasses, contacts, or protective eyewear?		
Have you ever had a sprain, strain, or swelling after injury?		
Have you broken or fractured any bones or dislocated any joints?		
Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? If yes, check box(es): [ ]Head [ ]Neck [ ]Back [ ]Chest [ ]Shoulder [ ]Upper Arm [ ]Elbow [ ]Wrist [ ]Hand [ ]Finger [ ]Hip [ ]Thigh [ ]Knee [ ]Shin/Calf [ ]Ankle/Foot		

Explanation:

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. I understand and acknowledge that truthful and accurate information is essential in properly determining whether the student should be cleared for athletic participation I hereby consent for the student named above, to be given medical care by the doctor selected by the school.

Signature of Parent/Guardian Signature of Student Athlete Date