Islander Middle School ATHLETIC HEALTH FORM
To be filled out by the student/parent

Student _____ Birth Date _____ Grade _____ Gender

_____ _____

Address _____ Hm. Phone _____ Wk. Phone _____

Physician's Name (Please Print) _____ Phone _____

Physician's Address _____

Date of last Tetanus Immunization? _____ Date of last Measles Immunization? _____

Explain "Yes" answers below	No	Yes
1. Overnight hospitalizations, operations or surgery? Dates	o	o
2. Are you presently taking any medication or pills?	o	o
3. Do you have any allergies/conditions that are life threatening* or affect school/sports?	o	o
4. Have you ever passed out during or after exercise?	o	o
Have you ever been dizzy during or after exercise?	o	o
Do you tire more quickly than your friends during exercise?	o	o
Have you ever had high blood pressure?	o	o
Have you ever been told that you have a heart murmur?	o	o
Have you ever had racing of your heart or skipped heartbeats?	o	o
Anyone under 50 yrs old in the family die of heart problems?	o	o
5. Do you have any skin problems?	o	o
6. Have you ever had a head injury?	o	o
Have you ever been knocked out or unconscious?	o	o
Have you ever had a seizure?	o	o
Have you ever had a stinger, burner or pinched nerve?	o	o
7. Have you ever had heat or muscle cramps?	o	o
Have you ever been dizzy or passed out in the heat?	o	o
8. Do you have trouble breathing or do you cough during or after activity?	o	o
9. Do you use any special equipment (pads, braces, mouth guard, etc?	o	o
10. Have you had any problems with your eyes or vision?	o	o
Do you wear glasses or contacts or protective eye or vision?	o	o
11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?	o	o

o Head o Shoulder o Thigh o Neck o Elbow o Knee o Chest

o Foot o Forearm o Shin/calf o Back o Wrist o Ankle o Hip o Hand

Explain "Yes" answers to Questions 1-11 above: _____

_____

_____

*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 and formulation of a nursing plan to implement the order.

The signature below indicates that a parent/guardian and the participating student acknowledge they have carefully read this form and the above information is true.

STUDENT SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

Mercer Island School District #400

Islander Middle School PHYSICAL EXAMINATION

To be completed by a physician with signature for sports clearance once each school year
Mercer Island School District requires a physical exam every two years for sports participation

Name: _____ Date: _____

Height: _____ Weight: _____ BP:_____ /_____ Pulse: _____

Vision: R 20/_____ L 20/_____ Corrected: Y N Pupils _____

	Normal	Abnormal Findings	Initials
Cardiopulmonary			
Pulse			
Heart			
Lungs			
Skin			
Abdominal			
Genitalia			
Musculoskeletal			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			
Other			

Clearance:

A. Cleared

B. Cleared after completing evaluation/rehabilitation for: _____

C. Not Cleared for: Collision o

Contact o

Activity level o ___ Strenuous ___ Moderately strenuous ___ Nonstrenuous

Due to: _____

Recommendation: _____

_____

Name of Physician: (PLEASE PRINT) _____ Phone:

_____ _____

Physician's Signature: _____ Date of Exam: _____

Date of Signature: _____

Date_____