Hawaii State Department of Education
PHYSICAL EXAMINATION FOR ATHLETES

Student’s Name ___________________________ M/F ___ Date of Birth __/__/______ Grade ___
(Print) Last First MI

Address ___________________________ Home Phone ___________ Student Resides With ______
Street No. City State Zip Code

Fall Sport ____________________ Winter Sport ____________________ Spring Sport ____________

Father’s/Guardian’s Name ____________________ Bus. Phone ___________ Cell or Pager ______

Mother’s/Guardian’s Name ____________________ Bus. Phone ___________ Cell or Pager ______

Emergency Contact _________________________ Bus. Phone ___________ Cell or Pager ______

Health and/or Insurance Carrier ________________________ Policy # ____________

To be completed by Physician only
Height _________ feet & inches  Weight ______lbs     Blood Pressure______/______   Pulse______ bpm

Vision: R 20/______ L 20/______ Corrected: Yes  No  Pupils: Equal ____  Unequal __

Asthma _________ (Medication Used)  Diabetes ____________ (Medication Used) Allergies _______________ (Medication Used)

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>NORMAL</th>
<th>COMMENTS</th>
<th>INITIALS</th>
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<tbody>
<tr>
<td>Appearance</td>
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<td>Eyes/ears/nose/throat</td>
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<td>Hearing</td>
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<td>Lymph nodes</td>
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<td>Heart/Murmurs</td>
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<td>Pulses</td>
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<td>Lungs</td>
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<td>Abdomen</td>
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<td>Skin</td>
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<td>Genitalia</td>
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<td>MUSCULOSKELETAL</td>
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<td>Neck</td>
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<td>Shoulder/arm</td>
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<td>Elbow/forearm</td>
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<td>Wrist/hand/fingers</td>
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<td>Knee</td>
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<td>Calf/ankle</td>
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<td>Foot/toes</td>
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<td>Other</td>
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Clearance:
A. Cleared for all sports __________________
B. Cleared after completing evaluation/rehabilitation for __________________________________
C. Not cleared for:  ☐ Collision  ☐ Contact  ☐ Non contact  ☐ Strenuous  ☐ Moderately Strenuous  ☐ Non-strenuous

Due to _________________________________

Physician’s Recommendation ___________________________ Date of Physical Exam ____________

Name of Physician ____________________ Address ______________________________________

Signature of Physician ____________________ Telephone ___________ Fax Number ____________

RS 06-1385 (Rev. of RS 03-0094)
Parent/Guardian and Student to fill out before Physical Examination

Explain “Yes” answers below. Circle question you don’t know the answer to.

1. Has a doctor ever denied or restricted your participation in sports for any reason?
   Yes  No
2. Do you have an ongoing medical condition (like diabetes or asthma)?
   Yes  No
3. Are you currently taking any prescription or nonprescription (over the counter) medicines or pills?
   Yes  No
4. Do you have allergies to medicines, pollens, foods or stinging insects?
   Yes  No
5. Have you ever passed out or nearly passed out during exercise?
   Yes  No
6. Have you ever passed out or nearly passed out after exercise?
   Yes  No
7. Have you ever had discomfort, pain or pressure in your chest during exercise?
   Yes  No
8. Does your heart race or skip beats during exercise?
   Yes  No
9. Has a doctor ever told you that you have: (circle all that apply)
   High blood pressure  A heart murmur
   High Cholesterol  A heart infection
10. Does anyone in your family have a heart problem?
    Yes  No
11. Has anyone in your family died for no apparent reason?
    Yes  No
12. Does anyone in your family have a heart problem?
    Yes  No
13. Has any family member or relative died of heart problems or of sudden death before age 50?
    Yes  No
14. Does anyone in your family have Marfan Syndrome?
    Yes  No
15. Have you ever spent the night in a hospital?
    Yes  No
16. Have you ever had surgery?
    Yes  No
17. Have you ever had an injury, like sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game?
    Yes  No
18. Have you ever had any broken or fractured bones or dislocated joints? If yes, list affected area:
    Yes  No
19. Have you ever had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, list affected area:
    Yes  No
20. Have you ever had a stress fracture?
    Yes  No
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?
    Yes  No
22. Do you regularly use a brace or assistive device?
    Yes  No
23. Has a doctor ever told you that you have asthma or wheezing?
    Yes  No

EXPLAIN “YES” answers here:
(Add additional pages if necessary)

24. Do you cough, wheeze or have difficulty breathing during or after exercise?
    Yes  No
25. Have you ever used an inhaler or taken asthma medicine?
    Yes  No
26. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?
    Yes  No
27. Have you had infectious mononucleosis (mono) within the last month?
    Yes  No
28. Do you have any rashes, pressure sores, or other skin problems?
    Yes  No
29. Have you had a herpes skin infection?
    Yes  No
30. Have you ever had a head injury or concussion?
    Yes  No
31. Have you ever been hit in the head and been confused or lost your memory?
    Yes  No
32. Have you ever had a seizure?
    Yes  No
33. Do you have headaches with exercise?
    Yes  No
34. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?
    Yes  No
35. Have you ever been unable to move your arms or legs after being hit or falling?
    Yes  No
36. When exercising in the heat, do you have severe muscle cramps, or become ill?
    Yes  No
37. Has a doctor told you that you, or does someone in your family have sickle cell trait or sickle cell disease?
    Yes  No
38. Have you had any problems with your eyes or vision?
    Yes  No
39. Do you wear glasses or contact lenses?
    Yes  No
40. Do you wear protective eyewear, such as goggles or a face shield?
    Yes  No
41. Are you happy with your weight?
    Yes  No
42. Would you like to lose weight?
    Yes  No
43. Would you like to gain weight?
    Yes  No
44. Has anyone recommended you change your weight or eating habits?
    Yes  No
45. Do you limit or carefully control what you eat?
    Yes  No
46. Do you have any concerns that you would like to discuss with a doctor?
    Yes  No
47. Have you ever had a menstrual period?
    Yes  No
48. How many periods have you had in the last 12 months?
    
I hereby verify to the best of my knowledge that the answers which have been provided to the above questions are correct.

Signature of Student  Signature of Parent/Guardian  Date

The student and parent/guardian consent and authorize school officials through an Athletic Health Care Trainer (AHCT), qualified coach/staff, or physician as determined by the school, to provide any first aid and/or emergency care as well as follow-up first aid or medical treatment that may be reasonably necessary for the student as determined by a school official in the course of athletic practice, competition or travel.

The student and parent/guardian further consent and authorize the school’s AHCT to provide appropriate therapeutic modalities in order to return student to athletic competition, such care to be conducted under the direction of a physician.

The student and parent/guardian hereby consent to the release of medical information by physician to school to obtain information regarding the medical history, records of injury or surgery, serious illness, and rehabilitation results of the student from his/her physician(s). We understand that the purpose of this request for medical information is to assist the school in the management or rehabilitation of an injury/illness. This information is confidential and except as provided in this release will not be otherwise released by the parties in charge of the information. This release remains valid until revoked by the adult student or parent/guardian in writing.

Signature of Student  Signature of Parent/Guardian  Date

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