



ENUMCLAW HIGH SCHOOL



Physical Evaluation Form

Student Name _____ AGE ____ DOB ____ / ____ / ____ Gender: M F
 School _____ Grade _____ Teacher/Advisor/Coach _____
 Parent/Guardian Name _____ Phone H) _____ W) _____ C) _____
 Parent/Guardian Name _____ Phone H) _____ W) _____ C) _____
 Address, City, Zip _____
 Licensed Health Care Provider _____ Phone _____

Medical Concerns

	Yes	No	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Date of last seizure: _____
Latex Allergy	<input type="checkbox"/>	<input type="checkbox"/>	
Allergic Reactions (plant, insect, food, medicine)	<input type="checkbox"/>	<input type="checkbox"/>	Type/emergency medication: _____
Recent exposure to contagious disease	<input type="checkbox"/>	<input type="checkbox"/>	Disease: _____
Safety Concerns/Sleepwalking/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	If yes, explain: _____
Special Dietary Needs	<input type="checkbox"/>	<input type="checkbox"/>	If yes, explain: _____
Other	<input type="checkbox"/>	<input type="checkbox"/>	If yes, explain: _____
Is student currently taking medication	<input type="checkbox"/>	<input type="checkbox"/>	If yes, list medications needed for this activity: _____

Other information or direction from parent: _____

Parent Signature: _____ **Date:** _____

PHYSICAL EXAMINATION FOR PHYSICIAN USE ONLY

Age: _____ Pulse: _____ Blood Pressure: _____ Height: _____ Weight: _____

FOR WRESTLERS ONLY: Minimum Wrestling Weight: _____ **Visual Acuity: Left 20/** _____ **Right 20/** _____

Normal		Abnormal	Normal		Abnormal
<input type="checkbox"/>	1. Head	<input type="checkbox"/>	<input type="checkbox"/>	8. Genitalia	<input type="checkbox"/>
<input type="checkbox"/>	2. Eyes (pupils), ENT	<input type="checkbox"/>	<input type="checkbox"/>	9. Neurologic	<input type="checkbox"/>
<input type="checkbox"/>	3. Teeth	<input type="checkbox"/>	<input type="checkbox"/>	10. Skin	<input type="checkbox"/>
<input type="checkbox"/>	4. Chest	<input type="checkbox"/>	<input type="checkbox"/>	11. Physical Maturity	<input type="checkbox"/>
<input type="checkbox"/>	5. Lungs	<input type="checkbox"/>	<input type="checkbox"/>	12. Spine, Back	<input type="checkbox"/>
<input type="checkbox"/>	6. Heart	<input type="checkbox"/>	<input type="checkbox"/>	13. Shoulders, Upper extremities	<input type="checkbox"/>
<input type="checkbox"/>	7. Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	14. Lower extremities	<input type="checkbox"/>

Limited participation (describe limitations, restrictions): _____

Recommendations (equipment, taping, rehabilitation, etc.): _____

Examiner's Signature: _____ **Date:** _____

Print Examiner's Name: _____ **Examiner's Phone:** _____