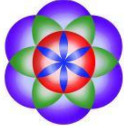

# Emerson Waldorf School
## PRE-PARTICIPATION PHYSICAL EXAM

Name ______________________________Date of Birth______________________Grade _______
Home Phone________________Emergency Phone______________Other Phone ____________

| | | | | |
|---|---|---|---|---|
| **Answer the following questions as accurately as possible** | **Yes** | **No** | **Don't Know** | **Elaboration of Yes Answers** |
| Has anyone in your family (grandparents, parents, brothers, sisters) died before the age of 50? | | | | |
| Have you ever stopped exercising because you were dizzy or have you ever passed out during exercise? | | | | |
| Have you ever been told you have a heart problem? | | | | |
| Do you ever experience wheezing, coughing or difficulty breathing while exercising? Do you use an inhaler? | | | | |
| Have you ever broken a bone, dislocated a joint, or had to wear a cast? List: | | | | |
| Have you ever had a heat-related illness (heat stroke, heat exhaustion) or had difficulty exercising in warm/hot weather? | | | | |
| Do you have a chronic illness or see a doctor regularly for any particular problem? | | | | |
| Do you take any medications? List: | | | | |
| Are you allergic to any medications, bee stings, or foods? List: | | | | |
| Do you have only one paired organ (eyes, kidneys, testicles)? | | | | |
| Do you wear contact lenses or eyeglasses? | | | | |
| Do you feel you are overweight or underweight or are you on a special diet? | | | | |
| Has a doctor ever told you to give up sports or limit your activity because of a healthy related problem? | | | | |
| Do you have anything you would like to talk to the doctor about? | | | | |
| **Insurance Company_________________** | **Policy Number________________________** | | | |

**To Parents/Guardians:**

I have read and agree with the answering of the above medical history questions. I recognize there are inherent risks in all athletic events including severe trauma such as head/spinal cord injuries, paralysis and even death. I certify that my child is covered by accident/health insurance. This coverage is by virtue of :

**Insurance Company_________________________ Policy Number ___________________**

**Parent's Signature_______________________________________Date_________________**

**Athlete's Name:** ______________________________________

| Height | ______ | Weight | ______ | Vision (Rt) | ______ | Vision (L) | ______ | Blood Pressure | ______ |
|---|---|---|---|---|---|---|---|---|---|

**Musculoskeletal Exam:**

| | Normal | Abnormal | Record laxity, weakness, instability, decreased ROM or positive tests | |
|---|---|---|---|---|
| Neck | | | | |
| Shoulder | | | | |
| Spine | | | | |
| Hip | | | | |
| Knee | | | | |
| Ankle | | | | |
| Feet | | | | |
| Other | | | | |

**Physician's Exam:**

| | Normal | Abnormal | Comments | |
|---|---|---|---|---|
| ENT | | | | |
| Heart | | | | |
| Lungs | | | | |
| Abdomen | | | | |
| Skin | | | | |
| Other | | | | |

**Physician's Assessment and Comments:**

**Recommendations:**

___________ 1. Authorized to compete without restriction.
___________ 2. Authorized to compete in non-contact sports only.
___________ 3. Authorization deferred until __________________________________

Physician's Signature: I certify that I have examined the above student and I am licensed to practice medicine in the state of North Carolina.

**Signature:** ______________________________________ **Date:** _______________________

**Printed name:** ___________________________________ **Office Phone:** _______________