STUDENT HEALTH REVIEW/EXAM

SECTION A: To be completed by parent or guardian.

Student Last Name | **Student First Name** | **MI** | **Date of birth** ____/____/____ | **Grade**

Address | **City** | **Zipcode**

Phone | **Emergency Phone** | **Date of last physical exam** ______/______/______

Last tetanus shot ____/____/____ | **Last measles shot** ____/____/____ | **Last TB skin test** ____/____/____ | **TB skin test result** | **TB status**

		YES	NO
1.	Have you ever been hospitalized?	☐	☐
	Have you ever had surgery?	☐	☐
2.	Are you presently taking any medications or pills?	☐	☐
3.	Do you have any allergies *(medicine, bees or other stinging insects)*?	☐	☐
4.	Have you ever passed out during or after exercise?	☐	☐
	Have you ever been dizzy during or after exercise?	☐	☐
	Have you ever had chest pain during or after exercise?	☐	☐
	Do you tire more quickly than your friends during exercise?	☐	☐
	Have you ever had high blood pressure?	☐	☐
	Have you ever been told that you have a heart murmur?	☐	☐
	Have you ever had racing of your heart or skipped beats?	☐	☐
	Has anyone in your family died of heart problems or sudden death before age 50?	☐	☐
5.	Do you have any skin problems *(itching, rashes, acne)*?	☐	☐
6.	Have you ever had a head injury?	☐	☐
	Have you ever been knocked out or unconscious?	☐	☐
	Have you ever had a seizure?	☐	☐
	Have you ever had a stinger, burner or pinched nerve?	☐	☐
7.	Have you ever had heat or muscle cramps?	☐	☐
	Have you ever been dizzy or passed out in the heat?	☐	☐
8.	Do you have trouble breathing or do you cough during or after activity?	☐	☐
9.	Do you use any special equipment *(pads, braces, neck rolls, mouth guards, eye guards, etc.)*?	☐	☐
10.	Have you ever had problems with your eyes or vision?	☐	☐
	Do you wear glasses or contacts or protective eye wear?	☐	☐
11.	Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries in any of the following bones or joints?	☐	☐
	___Head ___Shoulder ___Thigh ___Neck ___Elbow ___Knee ___Chest		
	___Forearm ___Shin/calf ___Back ___Wrist ___Ankle ___Hip ___Hand		
12.	Have you ever had other medical problems *(infectious mononucleosis, diabetes, etc.)*?	☐	☐
13.	Have you had any medical problem or injury since your last evaluation?	☐	☐

14. When was your first menstrual period? ____________________

When was your last menstrual period? ____________________

What was the longest time between your periods last year? ____________________

Explain all “yes” answers: ____________________

____

____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Student Signature: ____________________ Date: __________

Parent/Guardian Signature: ____________________ Date: __________

ALASKA SCHOOL ACTIVITIES ASSOCIATION, INC.

4048 Laurel Street, Suite 203 • Anchorage, AK 99508 • (907) 563-3723 • Fax 561-0720 • www.asaa.org

STUDENT HEALTH REVIEW/EXAM

SECTION B: To be completed by physician, physician assistant or advanced nurse practitioner

Student Last Name | **Student First Name** | **MI** | **Date of birth** ____/____/____ | **Grade**

Height | **Weight** | **Blood Pressure** | **Pulse**

Vision — Right Eye 20/ | **Vision — Left Eye** 20/ | **Vision Corrected?** ☐ Yes ☐ No | **Pupils**

	NORMAL	ABNORMAL FINDINGS				INITIALS
Cardiopulmonary						
Pulse						
Heart						
Lungs						
Tanner Stage	1	2	3	4	5	
Skin						
Abdominal						
Genitalia						
Musculoskeletal						
Neck						
Shoulder						
Elbow						
Wrist						
Hand						
Back						
Knee						
Ankle						
Foot						
Other						

Clearance:

☐ Cleared

☐ Cleared after completed evaluation/rehabilitations for: ____________________

☐ Not cleared for: ☐ Collision ☐ Contact ☐ Noncontact ☐ Strenuous ☐ Moderately Strenuous ☐ Nonstrenuous

Due to: ____________________

____

Name of M.D., P.A. or ANP (circle which) | **Signature** | **Date** ____/____/____

Address | **Phone**