

# STUDENT HEALTH REVIEW/EXAM

**SECTION A: To be completed by parent or guardian.**

<b>Student Last Name</b> <input style="width: 95%;" type="text"/>	<b>Student First Name</b> <input style="width: 95%;" type="text"/>	<b>MI</b> <input style="width: 95%;" type="text"/>	<b>Date of birth</b> <input style="width: 95%;" type="text"/>	<b>Grade</b> <input style="width: 95%;" type="text"/>
<b>Address</b> <input style="width: 95%;" type="text"/>		<b>City</b> <input style="width: 95%;" type="text"/>		<b>Zipcode</b> <input style="width: 95%;" type="text"/>
<b>Phone</b> <input style="width: 95%;" type="text"/>	<b>Emergency Phone</b> <input style="width: 95%;" type="text"/>		<b>Date of last physical exam</b> <input style="width: 95%;" type="text"/>	
<b>Are your immunizations up to date</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Last tetanus shot</b> <input style="width: 95%;" type="text"/>	<b>Last measles shot</b> <input style="width: 95%;" type="text"/>	<b>Last TB skin test</b> <input style="width: 95%;" type="text"/>

	YES	NO
1. Have you ever been hospitalized? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery? .....	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you presently taking any medications or pills? .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any allergies ( <i>medicine, bees or other stinging insects</i> )? .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever passed out during or after exercise? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy during or after exercise? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you tire more quickly than your friends during exercise? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had high blood pressure? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told that you have a heart murmur? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped beats? .....	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family died of heart problems or sudden death before age 50? .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any skin problems ( <i>itching, rashes, acne</i> )? .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had a head injury? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a concussion? If yes, how many _____ .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out or unconscious? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from migraines? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a stinger, burner or pinched nerve? .....	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had heat or muscle cramps? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy or passed out in the heat? .....	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have trouble breathing or do you cough during or after activity? .....	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you use any special equipment ( <i>pads, braces, neck rolls, mouth guards, eye guards, etc.</i> )? .....	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever had problems with your eyes or vision? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear glasses or contacts or protective eye wear? .....	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries in any of the following bones or joints? .....	<input type="checkbox"/>	<input type="checkbox"/>
___Head    ___Shoulder    ___Thigh    ___Neck    ___Elbow    ___Knee    ___Chest		
___Forearm    ___Shin/calf    ___Back    ___Wrist    ___Ankle    ___Hip    ___Hand		
12. Have you ever had other medical problems ( <i>infectious mononucleosis, diabetes, etc.</i> )? .....	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you had any medical problem or injury since your last evaluation? .....	<input type="checkbox"/>	<input type="checkbox"/>
14. Are you Diabetic? .....	<input type="checkbox"/>	<input type="checkbox"/>
15. Are you Asthmatic? .....	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you have any allergies? .....	<input type="checkbox"/>	<input type="checkbox"/>
List all allergies: _____		
17. 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**

<b>Student Last Name</b> <input style="width: 95%;" type="text"/>	<b>Student First Name</b> <input style="width: 95%;" type="text"/>	<b>MI</b> <input style="width: 95%;" type="text"/>	<b>Date of birth</b> <input style="width: 95%;" type="text"/>	<b>Grade</b> <input style="width: 95%;" type="text"/>
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<b>Height</b> <input style="width: 95%;" type="text"/>	<b>Weight</b> <input style="width: 95%;" type="text"/>	<b>Blood Pressure</b> <input style="width: 95%;" type="text"/>	<b>Pulse</b> <input style="width: 95%;" type="text"/>
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<b>Vision — Right Eye</b> <input style="width: 95%;" type="text"/>	<b>Vision — Left Eye</b> <input style="width: 95%;" type="text"/>	<b>Vision Corrected?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Pupils</b> <input style="width: 95%;" type="text"/>
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	NORMAL	ABNORMAL FINDINGS	INITIALS
Cardiopulmonary			
Pulse			
Heart			
Lungs			
Skin			
Abdominal			
Genitalia			
Musculoskeletal			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			
Other			

**Clearance:**     Cleared  
 Cleared after completed evaluation/rehabilitations for (Specific Sports): \_\_\_\_\_  
 Not cleared for:     Collision     Contact     Noncontact     Strenuous  
    Moderately Strenuous     Nonstrenuous

Due to: \_\_\_\_\_  
\_\_\_\_\_

<b>Name of M.D., P.A. or ANP (circle which)</b> <input style="width: 95%;" type="text"/>	<b>Signature</b> <input style="width: 95%;" type="text"/>	<b>Date</b> <input style="width: 95%;" type="text"/>
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<b>Address</b> <input style="width: 95%;" type="text"/>	<b>Phone</b> <input style="width: 95%;" type="text"/>
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