

Hoosick Falls Central School Pupils Health Assessment

Name _____ Date _____
 Age _____ Grade _____ Male Female

Student History

Check the sport(s) that you will be playing:

- Baseball Basketball Cheerleading Cross-Country Field Hockey Football Track/Field
 Gymnastics Wrestling Soccer Softball Volleyball Golf Other _____

Please answer the following questions by circling either yes or no:

- | | | |
|---|-----|----|
| 1) Have you ever been hospitalized (overnight)? | Yes | No |
| Have you ever had surgery? | Yes | No |
| 2) Are you currently taking any medications? | Yes | No |
| 3) Do you have any allergies (medicine, bee stings etc)? | Yes | No |
| 4) Have you ever passed out during exercise (not from heat)? | Yes | No |
| Have you ever been dizzy during exercise (not from heat)? | Yes | No |
| Have you ever had chest pain? | Yes | No |
| Do you tire more quickly than your friends during exercise? | Yes | No |
| Have you ever had high blood pressure? | Yes | No |
| Have you ever been told you have a heart murmur? | Yes | No |
| Has your heart ever raced or skipped a beat? | Yes | No |
| Has anyone in your family died of heart problems or sudden death at age 40 or younger? | Yes | No |
| Does anyone in your family have Marfan's syndrome? | Yes | No |
| 5) Do you have any skin problems (itching, rashes, breaking out)? | Yes | No |
| 6) Have you ever had a head injury? | Yes | No |
| Have you ever been knocked out? | Yes | No |
| Have you ever had a seizure? | Yes | No |
| Have you ever had a burner/stinger (pain from neck to arm)? | Yes | No |
| 7) Have you ever had heat cramps? | Yes | No |
| Have you ever been dizzy or passed out in the heat? | Yes | No |
| 8) Do you use special pads or braces? | Yes | No |
| 9) Have you ever injured (broken/fractured, sprained, dislocated)? | | |
| <input type="checkbox"/> Ankle <input type="checkbox"/> Back <input type="checkbox"/> Chest/Ribs <input type="checkbox"/> Elbow <input type="checkbox"/> Foot/Toes <input type="checkbox"/> Forearm <input type="checkbox"/> Hand/Fingers <input type="checkbox"/> Hip
<input type="checkbox"/> Knee <input type="checkbox"/> Neck <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Shoulder <input type="checkbox"/> Thigh <input type="checkbox"/> Upper Arm <input type="checkbox"/> Wrist | | |
| 10) Have you ever had? | | |
| <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Eye/ear injury <input type="checkbox"/> Headache(frequent) <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia(s) <input type="checkbox"/> Measles
<input type="checkbox"/> Mononucleosis <input type="checkbox"/> Sickle cell trait/disease <input type="checkbox"/> Stomach ulcer(s) <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Any stress fractures | | |
| 11) When was your last tetanus shot? _____ | | |
| 12) About your weight: Do you think you are <input type="checkbox"/> Just Right? <input type="checkbox"/> Too Heavy? <input type="checkbox"/> Too Light? | | |
| 13) Males: Number of testicles _____ Females: Age of onset for menstrual cycles _____ Are they regular? _____ | | |

Parent/Guardian Signature _____

Date _____

Physician/Provider Signature _____

Date _____

** Please review this form and bring with you on the day of your physical – Thank You **

Hoosick Falls Central School Pupils Health Physical Examination

Name _____ Date _____
 Age _____ Grade _____ Male Female

Height _____ Blood Pressure _____ Vision: Left Eye 20 / _____
 (sitting, left arm) Right Eye 20 / _____
 Weight _____ Both Eyes 20 / _____
 Body Fat _____ % Pulse _____ Corrected _____ Uncorrected _____
 (optional)

X = within normal limits

N/E = not examined

- 1. Skin
- 2. Head
- 3. Eyes (Pupils equal, react to light
and accommodation; extraocular
muscles intact; fundi)
- 4. Ears, Nose, Throat
- 5. Neck
- 6. Lymphatic
- 7. Respiratory
- 8. Cardiovascular
Heart (murmurs?)
Pulses

- 9. Abdomen
- 10. Genitals (optional)
- 11. Extremities
- 12. Neurologic
Reflexes
- 13. Orthopedic
Cervical spine/back
Arms/elbows/wrists/hands
Hips
Knees Ankles/feet
- 14. Developmental
Tanner staging (optional): 1-5

Preventive Health Issues Discussed with Student

Comments / Recommendations:

- Stretching emphasized Discussed fitness/ideal weight Discussed treatment of acute injuries
- Discussed prevention of sun/heat-related problems Discussed testicular cancer exams

Medical Clearance (as appropriate for age and development)

Full contact/collision level _____ Clearance deferred or no participation at this time because _____
 Limited contact/impact _____
 Noncontact: strenuous _____
 Noncontact: nonstrenuous _____

Provider Signature _____ Date _____