# 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** _________/_________/_________

**Are your immunizations up to date** ☐ Yes ☐ No | **Last tetanus shot** _____/______/____ | **Last measles shot** ______/______/___ | **Last TB skin test** ______/______/___

| | | YES | NO |
|---|---|---|---|
| **1.** | Have you ever been hospitalized? | ☐ | ☐ |
| **2.** | Have you ever had surgery? | ☐ | ☐ |
| **3.** | Are you presently taking any medications or pills? | ☐ | ☐ |
| **4.** | Have you ever passed out during or after exercise? | ☐ | ☐ |
| **5.** | Have you ever been dizzy during or after exercise? | ☐ | ☐ |
| **6.** | Have you ever had chest pain during or after exercise? | ☐ | ☐ |
| **7.** | Do you tire more quickly than your friends during exercise? | ☐ | ☐ |
| **8.** | Have you ever had high blood pressure? | ☐ | ☐ |
| **9.** | Have you ever been told that you have a heart murmur? | ☐ | ☐ |
| **10.** | Have you ever had racing of your heart or skipped beats? | ☐ | ☐ |
| **11.** | Has anyone in your family died of heart problems or sudden death before age 50? | ☐ | ☐ |
| **12.** | Do you have any skin problems *(itching, rashes, acne)*? | ☐ | ☐ |
| **13.** | Have you ever had a head injury? | ☐ | ☐ |
| **14.** | Have you ever had a concussion? If yes, how many_______ | ☐ | ☐ |
| **15.** | Have you ever been knocked out or unconscious? | ☐ | ☐ |
| **16.** | Do you suffer from migraines? | ☐ | ☐ |
| **17.** | Have you ever had a seizure? | ☐ | ☐ |
| **18.** | Have you ever had a stinger, burner or pinched nerve? | ☐ | ☐ |
| **19.** | Have you ever had heat or muscle cramps? | ☐ | ☐ |
| **20.** | Have you ever been dizzy or passed out in the heat? | ☐ | ☐ |
| **21.** | Do you have trouble breathing or do you cough during or after activity? | ☐ | ☐ |
| **22.** | Do you use any special equipment *(pads, braces, neck rolls, mouth guards, eye guards, etc.)*? | ☐ | ☐ |
| **23.** | Have you ever had problems with your eyes or vision? | ☐ | ☐ |
| 24. | Do you wear glasses or contacts or protective eye wear? | ☐ | ☐ |
| **25.** | 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

| | | YES | NO |
|---|---|---|---|
| **26.** | Have you ever had other medical problems *(infectious mononucleosis, diabetes, etc.)*? | ☐ | ☐ |
| **27.** | Have you had any medical problem or injury since your last evaluation? | ☐ | ☐ |
| **28.** | Are you Diabetic? | ☐ | ☐ |
| **29.** | Are you Asthmatic? | ☐ | ☐ |
| **30.** | Do you have any allergies *(medicine, bees or other stinging insects)*?? | ☐ | ☐ |

List all allergies:___________________________________________

**31.** When was your first menstrual period?___________________________________________
When was your last menstrual period? ___________________________________________
What was the longest time between your periods last year?___________________________________________

**32.** Explain all “yes” answers: ___________________________________________
___________________________________________

I hereby state that, to the best of my knowledge, my answers to the above questions are correct and give consent for my student to be examined.

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, advanced nurse practitioner or doctor of chiropractic**

*This form to be sent to the school (do not send to ASAA)*

| Student Last Name | Student First Name | MI | Date of birth | Grade |
|---|---|---|---|---|
| | | | _____/_____/_____ | |

| Height | Weight | Blood Pressure | Pulse |
|---|---|---|---|
| | | | |

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

| | 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: ________________________________________________________

________________________________________________________

| Name of M.D., P.A., ANP or DC (circle which) | Signature | Date |
|---|---|---|
| | | _____/_____/_____ |

| Address | Phone |
|---|---|
| | |

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