WATERVLIET CITY SCHOOL DISTRICT
Preparation Physical Evaluation

Date ____________________________

Name _________________________________Sex__________ Age__________ Date of Birth _____________

Grade ______________ Sport ______________________ ______________________ ______________________

Personal Physical _________________________ __________________________________ __________________
Address Phone

1. **Must be completed by a Parent and or Guardian**
2. **Must be completed in ink**
3. **ALL YES, ANSWERS MUST BE EXPLAINED**

EXPLAIN "YES" ANSWERS BELOW:

	Question	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.	How 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 then your friends during exercise?	___	___
	Have you ever had high blood pressure?	___	___
	Have you ever been told that you have a heart murmur?	___	___
	Has anyone in your family died of heart problems or sudden death before 50?	___	___
5.	Do you have any skin problems (Itching, rashes, and 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 stringer, burner, or pinched nerve?	___	___
7.	Have you ever had heat or muscle camps?	___	___
	Have you ever been dizzy or passed out in the heat?	___	___
8.	Do you have any trouble breathing or do you cough during /after exercise?	___	___
9.	Do you use any special equipment? (Pads, braces, neck rolls, mouth guards, eye guards, etc.)	___	___
10.	Have you had any 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 of any bones or joints?	___	___
	Head, Shoulder, Thigh, Neck, Elbow, Knee, Chest, Forearm, Shin/calf, Back, Wrist, Ankle, Hip, Hand, Foot		
12.	Have you had any other medical problems(infectious mononucleosis, blood clotting disorders, diabetics, etc?	___	___
13.	Have you had any other medical problems or injury since your last evaluation?	___	___
14.	When was your last tetanus shot? ____		
	When were you last measles immunization?	___	___
15.	When was your first menstrual period?	___	___
	When was your last menstrual period?	___	___
	What was the longest time between your periods last year?	___	___

EXPLAIN "YES" ANSWERS BELOW:

____
____
____
____

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

Date: ______________________ **Signature** ____
Parent/Guardian