

ANCHORAGE SCHOOL DISTRICT SPORTS PHYSICAL ~ HEALTH EXAMINATION FORM A

MEDICAL HISTORY TO BE COMPLETED BY LEGAL PARENT/GUARDIAN

Last Name (print) _____ First Name _____ Initial _____ Date of birth _____

- Have you or any members of your family under age 50 ever had a heart attack or sudden death? Y N
- Have you ever had any chest pain or passed out while exercising? Y N
- Do you cough or have trouble breathing during or after exercise? Y N
- Have you ever had an illness or injury that required hospitalization? Y N
- Have you ever made repeated visits to a doctor for an illness or injury? Y N
- Do you have any allergies? Y N
- Are you presently taking any medications? Y N
- In the past year, have you had a significant illness or injury? (i.e.: concussion) Y N

Explain any "Yes" answers: _____

Consent information:

- I hereby consent to emergency treatment, hospitalization or other medical treatment as may be necessary by a physician, qualified nurse, or hospital in the event of an injury or illness.
- I hereby consent to participation in ASAA approved interscholastic activities.
- I hereby consent to travel to and from ASAA activities via school approved transportation.
- I hereby waive on behalf of myself and the above student any liability of the school or ASAA organizationally or for any of its officers, agents or employees for injuries sustained in the interscholastic program.
- I accept financial responsibility for the above student in the event of an injury or illness.
- I accept legal responsibility of the above student in the event of an injury or illness.
- I hereby state that information submitted on this form is true.
- I hereby consent to abiding by the ASAA rules and regulations and school handbook

Student signature _____ Parent signature _____ Date _____

HEALTH EXAMINATION TO BE COMPLETED BY HEALTHCARE PROVIDER – MD, DO, ANP, PA

Age _____ Height _____ Weight _____ Blood pressure _____
Vision R/20 _____ Vision L/20 _____

Check any of the following that are abnormal and explain under "comments":

- | | | |
|--|--|--|
| <input type="checkbox"/> Eyes/ears/nose/throat | <input type="checkbox"/> Genitalia, Tanner stage _____ | <input type="checkbox"/> Knee/hip |
| <input type="checkbox"/> PERRLA | <input type="checkbox"/> Neurological | <input type="checkbox"/> Back |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Skin | <input type="checkbox"/> Ankles |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Head/neck | <input type="checkbox"/> Other musculoskeletal |
| <input type="checkbox"/> Liver/spleen/abdomen | <input type="checkbox"/> LAB: UA, HGB/HCT (as needed) | <input type="checkbox"/> DT (date): _____ |

Comments: _____

I certify that on this date, I have examined this student and find him/her physically able to compete in all supervised activities not crossed out:

- | | | | | | |
|-----------|------------|---------------|----------------|------------|-----------------|
| Baseball | Basketball | Bowling | Cheerleading | Diving | Flag Football |
| Football | Gymnastics | Hockey (boys) | Hockey (girls) | Riflery | Soccer |
| Softball | Swimming | Tennis | Track & Field | Volleyball | Weight Training |
| Wrestling | XC running | XC skiing | | | |

HCP Name (MD, DO, ANP, PA) (print) _____ Signature _____ Date of exam _____
Address _____
City _____ State _____
Phone _____ Zip _____

Healthcare provider stamp is required here