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 ☐ 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 medical assistant devices *(insulin pump, prosthetic, implanted device, 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	☐	☐
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: ____________________

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			

Clearance:

☐ Cleared

☐ Cleared with restriction: ____

☐ Not cleared. Explain why: ____

____

Name of M.D., D.O. P.A., ANP, CHAP or DC (cir-	Signature	Date
		____/____/____

Address	Phone