

STUDENT HEALTH REVIEW/EXAM

SECTION A: To be completed by parent or guardian.

| | | | | |
|--|---|--|---|--|
| Student Last Name <input style="width: 95%;" type="text"/> | Student First Name <input style="width: 95%;" type="text"/> | MI <input style="width: 95%;" type="text"/> | Date of birth <input style="width: 95%;" type="text"/> | Grade <input style="width: 95%;" type="text"/> |
| Address <input style="width: 95%;" type="text"/> | | City <input style="width: 95%;" type="text"/> | | Zipcode <input style="width: 95%;" type="text"/> |
| Phone <input style="width: 95%;" type="text"/> | Emergency Phone <input style="width: 95%;" type="text"/> | | Date of last physical exam <input style="width: 95%;" type="text"/> | |
| Are your immunizations up to date <input type="checkbox"/> Yes <input type="checkbox"/> No | | Last tetanus shot <input style="width: 95%;" type="text"/> | Last measles shot <input style="width: 95%;" type="text"/> | Last TB skin test <input style="width: 95%;" type="text"/> |

| | YES | NO |
|--|--------------------------|--------------------------|
| 1. Have you ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you presently taking any medications or pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have any allergies (<i>medicine, bees or other stinging insects</i>)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you tire more quickly than your friends during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been told that you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had racing of your heart or skipped beats? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has anyone in your family died of heart problems or sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any skin problems (<i>itching, rashes, acne</i>)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had a head injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a concussion? If yes, how many _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been knocked out or unconscious? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you suffer from migraines? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a stinger, burner or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had heat or muscle cramps? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy or passed out in the heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have trouble breathing or do you cough during or after activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you use any special equipment (<i>pads, braces, neck rolls, mouth guards, eye guards, etc.</i>)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever had problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear glasses or contacts or protective eye wear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries in any of the following bones or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| ___Head ___Shoulder ___Thigh ___Neck ___Elbow ___Knee ___Chest | | |
| ___Forearm ___Shin/calf ___Back ___Wrist ___Ankle ___Hip ___Hand | | |
| 12. Have you ever had other medical problems (<i>infectious mononucleosis, diabetes, etc.</i>)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you had any medical problem or injury since your last evaluation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Are you Diabetic? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Are you Asthmatic? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you have any allergies? | <input type="checkbox"/> | <input type="checkbox"/> |
| List all allergies: _____ | | |
| 17. When was your first menstrual period? _____ | | |
| When was your last menstrual period? _____ | | |
| What was the longest time between your periods last year? _____ | | |
| Explain all "yes" answers: _____ | | |

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

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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