

**RSD ACTIVITY CODE OF CONDUCT**  
*Cedarcrest High School "Home of the Red Wolves"*  
*Tolt Middle School "Home of the Thunderbirds"*  
**PHYSICAL EXAMINATION FORM**

NAME: \_\_\_\_\_

**PHYSICAL HISTORY QUESTIONNAIRE**

- |     | Yes                      | No                       |  |
|-----|--------------------------|--------------------------|--|
| 1a  | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any illness/injury recently, or do you have an illness/injury now?                |
| b   | <input type="checkbox"/> | <input type="checkbox"/> | Have you had a medical problem, illness or injury since your last exam?                        |
| c   | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any chronic or recurrent illnesses?  |
| d   | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any illness lasting more than a week?  |
| e   | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hospitalized overnight?   |
| f   | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any surgery other than a tonsillectomy?   |
| g   | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any injuries requiring treatment by a physician?                                  |
| h   | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc.)?      |
| 2   | <input type="checkbox"/> | <input type="checkbox"/> | Are you presently taking any medications (including birth control, vitamin, aspirin, etc.)?    |
| 3   | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any allergies (medicines, bees, food, or other factors)?                           |
| 4a  | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?       |
| b   | <input type="checkbox"/> | <input type="checkbox"/> | Do you tire more easily or quickly than your friends during exercise?                          |
| c   | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any problem with your blood pressure or your heart?                          |
| d   | <input type="checkbox"/> | <input type="checkbox"/> | Have any relatives had heart problems, heart attack or sudden death before they were 50?       |
| 5   | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any skin problems (acne, itching, rashes, etc.)?                                   |
| 6a  | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had fainting, convulsions, seizures, or severe dizziness?                        |
| b   | <input type="checkbox"/> | <input type="checkbox"/> | Do you have frequent severe headaches?   |
| c   | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a "stinger" or "burner" or "pinched nerve"?                                  |
| d   | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been knocked out or passed out?  |
| e   | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a neck or head injury?   |
| 7   | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had heat exhaustion, heat stroke, heat cramps, or similar heat-related problems? |
| 8   | <input type="checkbox"/> | <input type="checkbox"/> | Have you had asthma, or trouble breathing, or coughing during or after exercise?               |
| 9a  | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear eyeglasses, contact lenses, or protective eye wear?                                |
| b   | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any problems with your eyes or vision?  |
| 10  | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear any dental appliance such as braces, bridge, plate, retainer, etc.?                |
| 11a | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a knee injury?   |
| b   | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an ankle injury?   |
| c   | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever injured any other joint (shoulder, wrist, fingers, etc.)?                        |
| d   | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a broken bone or fracture?   |
| e   | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a cast, splint, or had to use crutches?                                      |
| f   | <input type="checkbox"/> | <input type="checkbox"/> | Are you required to use special equipment for competition (pads, braces, neck roll, etc.)?     |
| 12  | <input type="checkbox"/> | <input type="checkbox"/> | Has it been 5 or more years since your last tetanus shot? If so, when? _____                   |
| 13  | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any worries or concerns regarding your weight?                                     |
| 14  | <input type="checkbox"/> | <input type="checkbox"/> | FEMALES: Have you any menstrual problems?  |
| 15  | <input type="checkbox"/> | <input type="checkbox"/> | Have you any medical concerns about participating in your sport?                               |

**PHYSICAL EXAMINATION**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

Pulse: \_\_\_\_\_ Visual Acuity: Left 20/\_\_\_\_\_ Right 20/\_\_\_\_\_

Normal

- 1) Head
- 2) Eyes (pupils), ENT
- 3) Teeth
- 4) Chest
- 5) Lungs

Normal

- 6) Heart
- 7) Abdomen
- 8) Genitalia
- 9) Neuralgic
- 10) Skin

Normal

- 11) Physical Maturity
- 12) Spine, Back
- 13) Shoulders, Upper extremities
- 14) Lower extremities
- 15) Other

Overall Assessment:  Full Participation  Limited Participation (explain) \_\_\_\_\_  
 Recommendations (equipment, taping, rehabilitation): \_\_\_\_\_

Wrestling / Recommend Weight Class: (103 /112 /119 /125 /130 /135 /140 /145 /152 /160 /171 /189 /215 /275) \_\_\_\_\_

DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Examiner Physician Signature: \_\_\_\_\_ Printed Name \_\_\_\_\_ Phone \_\_\_\_\_

Signature: \_\_\_\_\_ Printed Name \_\_\_\_\_ Phone \_\_\_\_\_

(Examining Physician/second year clearance)