HOLLAND HALL

BOTH pages required
Physician's Signature required on BOTH pages *Updated 04/15/2024*

Physical Examination Form

Date of Exam _____

Student's Name _____ Date of Birth _____ Grade _____

Height _____ Weight _____ Pulse _____ BP _____ / _____

Vision: **R** 20/ _____ **L** 20/ _____ Corrected: **Y** / **N** Impact Testing: **Y** / **N**

	Normal	Abnormal Findings	Initials
1. General Appearance			
2. Eyes/Ears/Nose/Throat			
3. Neck			
4. Cardiovascular			
5. Chest/Lungs			
6. Abdomen			
7. Genitalia (male only)			
8. Skin			
9. Musculoskeletal			
Neck			
Back			
Shoulders/Arms			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

This section to be completed by physician only.

Clearance:	☐ Cleared for full participation without restriction.
	☐ Cleared for limited participation.
	☐ Not cleared for: Reason:
Special Instructions:	

Name & Title of Examiner (Print/Type) _____

Signature of Examiner _____ Date _____

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Holland Hall Medical History Form

This form to be completed by a parent/guardian, then reviewed and signed by a physician.

PLEASE PRINT
Student Name _____ Grade _____ Date of Birth _____

Holland Hall Sport(s) _____

Personal physician _____

Explain "Yes" answers below. Circle questions you don't know the answers to.

		YES	NO
1.	Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
	Do you have an ongoing or chronic illness?	☐	☐
2.	Have you ever been hospitalized overnight?	☐	☐
	Have you ever had surgery?	☐	☐
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	☐	☐
	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
4.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
	Have you ever had a rash or hives develop during or after exercise?	☐	☐
5.	Have 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 get tired more quickly than your friends do during exercise?	☐	☐
	Have you ever had racing of your heart or skipped heartbeats?	☐	☐
	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
	Have you ever become ill from exercising in the heat?	☐	☐
	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
	Do you get frequent muscle cramps when exercising?	☐	☐
	Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease ☐ Other _____		
6.	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50?	☐	☐
	Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia?	☐	☐
	Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?	☐	☐
	Has anyone in your family had unexpected fainting, unexplained seizures or near drowning?	☐	☐
7.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?	☐	☐

		YES	NO
8.	Have you ever had a head injury or concussion?	☐	☐
	Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
	Have you ever had a seizure?	☐	☐
	Do you have frequent or severe headaches?	☐	☐
	Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
9.	Do you cough, wheeze, or have trouble breathing during or after activity?	☐	☐
	Do you have asthma?	☐	☐
	Do you have seasonal allergies that require medical treatment?	☐	☐
	Do you or does someone in your family have sickle cell trait or disease?	☐	☐
10.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐
11.	Have you had any problems with your eyes or vision?	☐	☐
	Do you wear glasses, contacts or protective eyewear?	☐	☐
12.	Have you ever had a sprain, strain, or swelling after injury?	☐	☐
	Have you broken or fractured any bones or dislocated any joints?	☐	☐
	Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	☐	☐
	If yes, check appropriate box and explain below. ☐ Head ☐ Elbow ☐ Hip ☐ Neck ☐ Forearm ☐ Upper Arm ☐ Thigh ☐ Back ☐ Wrist ☐ Knee ☐ Chest ☐ Shoulder ☐ Hand ☐ Finger ☐ Ankle ☐ Foot ☐ Shin/calf		
13.	Do you want to weigh more or less than you do now?	☐	☐
	Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
14.	Do you feel stressed out?	☐	☐
15.	Have you or any member of your family been diagnosed with COVID-19 If YES, what date?_____	☐	☐

Physician Signature_____

Date: _____

The above information is true and complete to the best of my knowledge. I hereby give my informed consent for the above-mentioned Student to participate in sporting, physical education and other physical activities at Holland Hall. I understand and assume the risk of injury to Student as a result of his/her sport, athletic participation and/or physical activity. If Student becomes ill or is injured, necessary medical care can be instituted by physicians, coaches, trainers or other personnel properly trained. As a condition for participating in activities, I hereby hold Holland Hall harmless from any and all injuries, damages, or other claims of Student arising out of or relating to participation in these activities.

Signature of Parent/Guardian: _____ Signature of Student: _____ Date: _____