### General Questions

1. Has a doctor ever denied or restricted your participation in sports for any reason?  
2. Do you have any ongoing medical conditions? If so, please identify: □ Asthma □ Anemia □ Diabetes □ Infections Other: □  
3. Have you ever spent the night in the hospital?  
4. Have you ever had surgery?  
5. Have you ever gone out or nearly passed out during or after exercise?  
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?  
7. Does your heart ever race or skip beats (irregular beats) during exercise?  
8. 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: □  
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)  
10. Do you get lightheaded or feel more short of breath than expected during exercise?  
11. Have you ever had unexplained fainting, seizures, or near drowning?  
12. Do you get more tired or short of breath more quickly than your friends during exercise?  
13. Has any family member or relative died of heart problems? If so, check all that apply: □ Unexplained seizures □ Car accident □ Drowning □ Near drowning □ Sudden infant death syndrome  
14. Have you ever had an unexplained skin rash or a resulting infection?  
15. Do you have any unexplained skin lesions or warts that have changed recently?  
16. Do you have any dark lesions (moles) that have changed recently?  
17. Have you ever had surgery?  
18. Have you ever spent the night in the hospital?  
19. Other: □  
20. Do you regularly use a brace, orthotics, or other assistive device?  
21. Have you ever had or do you currently have a bone, muscle, or joint injury that bothers you?  
22. Do any of your joints become painful, swollen, feel warm, or look red?  
23. Do you have any history of juvenile arthritis or connective tissue disease?  
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?  
25. In the past year, have you used an inhaler or taken asthma medicine?  
26. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?  
27. Do you have groin pain or a painful bulge or hernia in the groin area?  
28. Have you had infectious mononucleosis (mono) within the last month?  
29. Have you had a herpes or MRSA skin infection?  
30. Have you ever had a head injury or concussion? If so, date of last occurrence: □  
31. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?  
32. Do you have a history of seizure disorder?  
33. Do you have headaches with exercise?  
34. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?  
35. Have you ever been unable to move your arms or legs after being hit or falling?  
36. Have you ever become ill while exercising in the heat?  
37. Do you get frequent muscle cramps when exercising?  
38. Do you or someone in your family have sickle cell trait or disease?  
39. Have you had any problems with your eyes or vision?  
40. Have you had any eye injuries?  
41. Do you wear glasses or contact lenses?  
42. Do you wear protective eyewear, such as goggles or a face shield?  
43. Do you worry about your weight?  
44. Are you trying to or has anyone recommended that you gain or lose weight?  
45. Are you on a special diet or do you avoid certain types of foods?  
46. Have you ever had an eating disorder?  
47. Do you have any concerns that you would like to discuss with a doctor?  
48. Do you take any nutritional or dietary supplements?  
49. Have you ever had a menstrual period?  
50. How many periods have you had in the last 12 months?  

For "Yes" responses, provide details below (use additional sheets if needed):
## KAMEHAMEHA SCHOOLS PHYSICAL EVALUATION FORM

### PART II: PHYSICAL EXAMINATION

<table>
<thead>
<tr>
<th>Student Name</th>
<th>Date of Birth</th>
<th>Grade</th>
<th>Student ID</th>
<th>□ Male</th>
<th>□ Female</th>
<th>/</th>
<th>□ Day</th>
<th>□ Boarder</th>
<th>/</th>
<th>□ Returning</th>
<th>□ New Student</th>
</tr>
</thead>
</table>

**PHYSICIAN TO COMPLETE (PLEASE COMPLETE ALL FIELDS)**

**Medical and Mental Health Conditions:**

**Allergies** (please list reaction):

**Current Medications:**  
Epi-Pen □ Yes □ No

**Additional Comments:**

**Medical and Mental Health Conditions:**

- **Height:**
- **Weight:**
- **BMI:**
- **Vision:** R 20 / L 20 / Corrected □ Yes □ No
- **BP:**
- **Pulse:**

### BP: Normal

**Abnormal Finding**

- **Appearance**
  - Marfan stigmata
- **Eyes/ears/nose/throat**
  - Pupils equal
  - Hearing
- **Lymph nodes**
- **Heart**
  - Murmurs (auscultation standing, supine, +/- Valsalva)
  - Location of point of maximal impulse (PMI)
- **Pulses**
  - Simultaneous femoral and radial pulses
- **Lungs**
- **Abdomen**
- **Genitourinary** (males only)
- **Skin**
  - HSV, lesions suggestive of MRSA, tinea corporis
- **Neurologic**
- **Musculoskeletal**
  - Neck/back
  - UE/shoulder/elbow/wrist/hand
  - LE/hip/knee/ankle/foot
  - Functional/duck walk/single leg hop
- **Mental Health**
  - Depression
  - Tobacco Use

**Tuberculosis screening** (for new students only)  
Date Placed: Date Read: Result: mm

**Please provide a copy of the immunization record**

### MEDICAL CLEARANCE

<table>
<thead>
<tr>
<th>School</th>
<th>Physical Education</th>
<th>Sports</th>
</tr>
</thead>
</table>

**Medically Cleared** (check all that apply)

- Yes
- No

**Restrictions or other Comments**

**I have reviewed the completed Health History form and completed the physical examination for the above-named student. Based on my clinical assessment, the student is cleared to attend school and participate in physical education and sports as indicated above.**

Name of Physician

Examination Date

Address

Phone

Signature of Physician

Today's Date

Revised 11/16