

Instructions: Complete this page and give it to your healthcare provider to review. Do not return this page to KS.

Student Name _____

Date of Birth _____

GENERAL QUESTIONS	Yes	No
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: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other:		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed 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: <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> 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 an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had any stress fracture, broken or fractured bones, or dislocated joints?		
18. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
19. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)?		
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?		

MEDICAL QUESTIONS	Yes	No
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 protective eyewear, such as goggles or a face shield?		
42. Do you worry about your weight?		
43. Are you trying to or has anyone recommended that you gain or lose weight?		
44. Are you on a special diet or do you avoid certain types of foods?		
45. Have you ever had an eating disorder?		
46. Do you have any concerns that you would like to discuss with a doctor?		
47. Do you take any nutritional or dietary supplements?		
48. Have you ever tested positive for COVID-19?		
FEMALES ONLY	Yes	No
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):

Signature of Parent/Guardian _____

Date _____

KAMEHAMEHA SCHOOLS PHYSICAL EVALUATION FORM

**Instructions: Complete the top two lines and have your healthcare provider complete the rest.
Please ensure all fields are completed before returning this form.**

Student Name: _____ **DOB:** _____ **Grade Entering:** _____ **ID #:** _____

Residency: Hawai'i State Out-of-state **Student Status:** Returning New / Day Boarding

PROVIDER TO COMPLETE (Blank fields will be considered as None or Normal)	
Medical and Mental Health Conditions: h/o COVID-19: <input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies/Reactions:
Current Medications & Dosage: Epi-Pen: <input type="checkbox"/> Yes <input type="checkbox"/> No Albuterol Inhaler: <input type="checkbox"/> Yes <input type="checkbox"/> No	Additional Comments:

Please send most current immunization record with PE form.

Height:	Weight:	BMI:	Vision: R 20 /	L 20 /	Corrected <input type="checkbox"/> Yes <input type="checkbox"/> No
BP:	Pulse:	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/ Vaping Use					

MEDICAL CLEARANCE			
	Medically Cleared (check all that apply)		Restrictions or other Comments
	Yes	No	
School	<input type="checkbox"/>	<input type="checkbox"/>	
Physical Education	<input type="checkbox"/>	<input type="checkbox"/>	
Sports	<input type="checkbox"/>	<input type="checkbox"/>	

I have reviewed the Health History and completed the physical examination documented on this form 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. I attest that I am a licensed physician (MD, DO), Nurse Practitioner (NP or APRN), or Physician Assistant (PA).

Name of Provider _____ Examination Date _____

Address _____ Phone _____

Signature of Provider _____ Today's Date _____