



KENTUCKY HIGH SCHOOL ATHLETIC ASSOCIATION
 2280 Executive Drive, Lexington, Kentucky 40505
 Athletic Participation/Physical Examination Form/Consent and Release
PART I - ATHLETE INFORMATION
(This part must be completed by the student)

Name (Last, First, Initial) _____ School Year _____
 Home Address (Street, City, State, Zip): _____
 Gender _____ Grade _____ School _____
 Date of Birth: _____ Birth Place (County, State): _____

Attendance History

Grade	School Name	School Year	Varsity Play – (Yes/No)?
9			
10			
11			
12			

I am planning to participate in the following (circle all you might try to play):

- Baseball Basketball Cross Country Football Golf Soccer Fast Pitch Softball
 Swimming Tennis Track and Field Volleyball Wrestling Cheerleading Other

PART II - MEDICAL HISTORY

This part must be completed by parent and student and presented to the authorized health care provider before the physical.

CHECK THE APPROPRIATE RESPONSE TO EACH ITEM:.....YES NO

1. Have you ever been hospitalized? YES NO
2. Have you ever had surgery of any kind (e.g., tonsillectomy). YES NO
3. Are you presently taking any medications or pills? YES NO
4. Do you have any allergies (medicine, bees, or other insects)? YES NO
5. Have you ever passed out during exercise? YES NO
6. Have you ever been dizzy during or after exercise? YES NO
7. Have you ever had chest pain during or after exercise? YES NO
8. Have you ever had high blood pressure? YES NO
9. Have you ever been told you have a heart murmur?..... YES NO
10. Have you ever had racing of your heart? YES NO
11. Has anyone in your family died of heart problems before 50?..... YES NO
12. Do you have any skin problems? (itching, rashes, acne) YES NO
13. Have you ever had a head injury? YES NO
14. Have you ever been knocked out or unconscious? YES NO
15. Have you ever had a seizure or suffer from epilepsy? YES NO
16. Have you ever had a stinger, burner or pinched nerve? YES NO
17. Have you ever had heat related problems? YES NO
18. Have you ever been dizzy or passed out in the heat? YES NO
19. Do you cough heavily, or breath heavily during activity? YES NO
20. Do you use any special equipment (e.g., knee brace)?..... YES NO
21. Have you had any problems with your eyes or vision?..... YES NO
22. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones? YES NO
23. Are you missing one of any paired organs (e.g., eyes) YES NO
24. Have you ever been diagnosed with any form of asthma? YES NO
25. Are you using an inhaler for asthma? YES NO
26. Are you diabetic? YES NO
27. Do you administer insulin to yourself? YES NO
28. Are you presently using tobacco in any form? YES NO
29. Do you have a history of sickle-cell anemia in your family? YES NO
30. Have you had any other medical problems? YES NO
31. Have you had a medical problem or injury within the last year?..... YES NO
32. Can you swim? YES NO
33. When was your last tetanus shot? _____