DANCE PHYSICAL EXAMINATION FORM 2023 – 2024

DANCE HSPVA
Kinder High School for the Performing and Visual Arts

Physicians can email completed form to the Kinder HSPVA to jcarothe@houstonisd.org , *please list dancers Last Name and Physical 2023* – in subject line. Physicals are due first day of school August 28. Dance Office would prefer a hard copy from Physician if possible.

STUDENT'S NAME:____BIRTHDATE:__________________AGE:_______SEX: M F GRADE:_______

HOME ADDRESS:____ZIP: ________________PHONE:________________________________

PARENT/GUARDIAN'S NAME

MOTHER:____BUS PH:___________________________Cell PH:_________________________

FATHER:____BUS PH:___________________________Cell PH:_________________________

* *

MEDICAL HISTORY:

LIST ANY OPERATIONS/FRACTURES/CHRONIC HEALTH PROBLEMS AND THE DATES

IMMUNIZATION TYPES & DATES: (Attach - COPY OF SHOT RECORDS)

ALLERGIES:____

WEIGHT____________HEIGHT____________PULSE_____________BLOOD PRESSURE_________________

VISION R20/______ L20/______ Corrected Yes / No PUPILS Equal / Unequal

LEGEND: N - NORMAL A – ABNORMAL NE - NOT EXAMINED

GENERAL BODY INFORMATION: EYES ______EARS _______NOSE________THROAT_______TEETH _______LIVER________SPLEEN _______

LUNGS_______CHEST_______LYMPH NODES________ABDOMINAL MASSES_______SKIN _______NEUROLOGICAL________

HEART AUSCULTATION SUPINE_______HEART AUSCULTATION STANDING________HEART LOWER EXTREMITY PULSES________

PULSES _______MARFAN'S STIGMATA(arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)_______

JOINT FUNCTIONS: NECK__________SHOULDERS__________ELBOWS__________WRISTS__________HANDS__________

HIPS________KNEES_________ANKLES_________FEET__________BACK___________

DESCRIPTION OF ABNORMAL FINDINGS OR ANY RECENT INJURIES/ILLNESSES OR SURGERIES:

____

____

I CERTIFY THAT I HAVE EXAMINED THIS STUDENT AND HE/SHE MAY PARTICIPATE IN THE STRENUOUS PHYSICAL ACTIVITY OF THE HSPVA DANCE DEPARTMENT FOR THREE HOURS EACH DAY.

SPECIAL INSTRUCTIONS OR SPECIAL LIMITATIONS: ____

DATE OF PHYSICAL EXAM: ___________________ SIGNATURE OF PHYSICIAN:____

PHYSICIAN'S PHONE # ______________________ PRINTED/TYPED NAME OF PHYSICIAN:________________________________

PHYSICIAN'S ADDRESS: ____

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY 2023-2024

This **MEDICAL HISTORY FORM** must be completed ***annually*** by parent (or guardian) and student in order for the student to participate in activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an event.

Student's Name: (print) _____ Sex _____ Age_____Date of Birth_____

Address _____Phone_____

Grade _____ School _____

Personal Physician _____Phone_____

Explain "Yes" answers in the box below. Circle question if you do not know the answer.

		Yes	No
1.	Have you had a medical illness or injury since your last check up or physical?	___	___
2.	Have you been hospitalized overnight in the past year?	___	___
	Have you ever had surgery?	___	___
3.	Have you ever had prior testing for the heart ordered by a physician?	___	___
	Have you ever passed out 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 high blood pressure or high cholesterol?	___	___
	Have you ever been told you have a heart murmur?	___	___
	Has any family member or relative died of heart problems or of sudden unexplained death before age 50?	___	___
	Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm?	___	___
	Have you had a severe viral infection (example - myocarditis or mononucleosis) within the last month?	___	___
	Has a physician ever denied or restricted your participation in activities for any heart problems?	___	___
4.	Have you ever had a head injury or concussion?	___	___
	Have you ever been knocked out, become unconscious, or lost your memory?	___	___
	If yes, how many times? _____		
	When was your last concussion? _____		
	How severe was each one? (Explain below)		
	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?	___	___
	Have you ever had a stinger, burner, or pinched nerve?	___	___
5.	Are you missing any paired organs?	___	___
6.	Are you under a doctor's care?	___	___
7.	Are you currently taking any prescription or non-prescription over-the-counter) medication or pills or using an inhaler?	___	___
8.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	___	___
9.	Have you ever been dizzy during or after exercise?	___	___
10.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	___	___
11.	Have you ever become ill from exercising in the heat?	___	___
12.	Have you had any problems with your eyes or vision?	___	___

		Yes	No
13.	Have you ever gotten unexpectedly short of breath with exercise?	___	___
	Do you have asthma?	___	___
	Do you have seasonal allergies that require medical treatment?	___	___
14.	Do you use any special protective or corrective equipment or devices that aren't usually used for your activity or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	___	___
15.	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	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/Calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper Arm	☐ Foot	

		Yes	No
16.	Do you want to weigh more or less than you do now?	___	___
17.	Do you feel stressed out?	___	___
18.	Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	___	___

Females Only

19. When was your first menstrual period? _____
When was your most recent menstrual period? _____
How much time do you usually have from the start of one period to the start of another? _____
How many periods have you had in the last year? _____
What was the longest time between periods in the last year? _____

Males Only

20. Are you missing a testicle? _____

21. Do you have any testicular swelling or masses? _____

EXPLAIN "YES" ANSWERS IN THIS BOX. ATTACH ANOTHER SHEET IF NECESSARY.

Initial of parent required after each statement:

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student. _____

If, between this date and the beginning of participation, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury. _____

I hereby state that, to the best of my knowledge, my answers to the above question are complete and correct. _____

STUDENT SIGNITURE:_____PARENT SIGNITURE:_____DATE:_____