STUDENT HEALTH REVIEW/EXAM

| | To be completed by | parent or g | uardia <u>n</u> | • | | | |
|--|---|--|-----------------|---------------|-----------------|--------|----------|
| Student Last Name | dent Last Name Student First Name | | MI | Date of birth | | G | rade |
| | | | | /_ | / | | |
| Address | | | City | | | Zipco | de |
| | | | | | | | |
| Phone | Emergency Pho | ne | | Date of | last physic | al ex | am |
| T Hone | | <u> </u> | | | idsi pilysid | ui ox | <u> </u> |
| | | | | | _/ | _/ | |
| Are your immunizations up to | Last tetanus | shot Last | t measles | shot | Last TB s | kin te | st |
| Yes No | | , | / | , | , | / | |
| | | | | | | YES | NO |
| Have you ever been hospitalized? Have you been diagnosed with COV Have you ever had surgery? Are you presently taking any medica Have you ever passed out during or a Have you ever been dizzy during or a Have you ever had chest pain during Do you tire more quickly than your a Have you ever had high blood press Have you ever had racing of your he Has anyone in your family died of he Do you have any skin problems (itch Have you ever had a head injury? Have you ever had a concussion? If Have you ever had a scizure? Have you ever had a stinger, burner o Have you ever had a stinger, burner o Have you ever had neat or muscle or Have you ever had problems with yo Do you have trouble breathing or do Do you wear glasses or contacts or p Have you ever sprained/strained, dislinjuries in any of the following bone HeadShoulderT ForearmShin/calfB Are you Diabetic? | itions, pills or supplements? after exercise? after exercise? or after exercise? arter exercise? arter exercise? art or skipped beats? eart problems or sudden death bing, rashes, acne)? yes, how many | vity? implanted device, d repeated swellin | etc.)? | Chest Hand | | | |
| 28. Are you Asthmatic? 29. Have you had any medical problem of the state of th | or injury since your last evaluat bees or other stinging insects | ion? | | | | | |
| 31. Have you ever had other medical pro32. When was your first menstrual periodWhen was your last menstrual periodWhat was the longest time between your | d? l? | | | | | | |
| 33. Explain all "yes" answers: | | | | | | | |
| I hereby state that, to the best of my know Student Signature: | | | _ | D | ate: | | |
| Parent/Guardian Signature: | | | | Da | te: | | |

2025-2026 ASAA Forms

STUDENT HEALTH REVIEW/EXAM

To be completed by physician, physician assistant, advanced nurse practitioner or doctor of chiropractic *This form to be sent to the school (do not send to ASAA)*

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| Part | ght Weight Male Female | |
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