HAWAII NATIONAL GUARD
YOUTH CHALLENGE ACADEMY

P.O. Box 5120 Hilo, HI 96720
Ph: (808) 430-4184 fax: (808) 933-1403

Doctor

IMMUNIZATION RECORD/TB CLEARENCE

Name _____
(Last) (First) (Middle Initial)

☐ Female Birthdate _____ /_____ / _____
☐ Male

Parent's Name _____ _____
(Mother/Guardian) (Father/Guardian)

IMMUNIZATIONS (VACCINES, DATES GIVEN: MONTH/DAY/YEAR)									
DTaP, DTP, DT, or Td		Pollo (IPV or OPV)		HIB *Haemphilus Influnxae* type B		Hepatitis B	Varicella	MMR	
Type	Date	Type	Date	Type	Date	Date	Date	Date	Check if done
									☐ DTaP
									☐ Polio
									☐ HIB
									☐ HEP
								Measles	☐ MMR
			OTHER						☐ Varic
			Date		Date		Date	Mumps	
								Rubella	

TUBERCOLOSIS EXAMINATION MANTOUX TEST (INTRADERMAL)			
Date Given	Date Read	Results (mm)	Physician, APRN, PA or Clinic

CHEST X-RAY			
Date	Results	Location	Physician, APRN, PA or Clinic

Physician, APRN, PA or Clinic
_____
(Signature or stamp if different from above)

Vision: _____ / _____

Glasses: _____

Comments:

Hawaii State Department of Education
PHYSICAL EXAMINATION FOR ATHLETES

Student's Name _____ M/F _____ Date of Birth ____ / ____ / _____ Grade _____
(Print) Last First MI Month Day Year

Address _____ Home Phone _____ Student Resides With _____
Street No. City State Zip Code

Fall Sport _____ Winter Sport _____ Spring Sport _____

Father/Legal Guardian's Name _____ Bus. Phone _____ Cellular Phone _____

Mother/Legal Guardian's Name _____ Bus. Phone _____ Cellular Phone _____

Emergency Contact _____ Bus. Phone _____ Cellular Phone _____
Name & Relationship

Emergency Contact _____ Bus. Phone _____ Cellular Phone _____
Name & Relationship

Emergency Contact _____ Bus. Phone _____ Cellular Phone _____
Name & Relationship

Health and/or Insurance Carrier _____ Policy # _____

The student and parent/legal guardian consent and authorize school officials through an Athletic Health Care Trainer (AHCT), qualified coach/staff, or physician as determined by the school, to provide any first aid and/or emergency care as well as follow-up first aid or medical treatment that may be reasonably necessary for the student as determined by a school official in the course of athletic practice, competition or travel.

The student and parent/legal guardian further consent and authorize the school's AHCT to provide appropriate therapeutic modalities in order to return the student to athletic competition, such care to be conducted under the direction of a physician.

The student and parent/legal guardian further consent and authorize the school's AHCT to administer baseline and/or post injury concussion management assessment in order to manage a concussion or suspected head trauma, such care to be conducted under the direction of a physician.

The student and parent/legal guardian hereby consent to the release of medical information by the physician to the school to obtain information regarding the medical history, records of injury or surgery, serious illness, and rehabilitation results of the student from his/her physician(s). We understand that the purpose of this request for medical information is to assist the school in the management or rehabilitation of an injury/illness. This information is confidential and except as provided in this release will not be otherwise released by the parties in charge of the information. This release remains valid until revoked by the adult student or parent/legal guardian in writing.

Student's Signature _____ Parent/Legal Guardian's Signature _____ Date _____

(Parent/Legal Guardian: Please Fill Out the Back Side of this Form)

To Be Completed By Physician Only

Height _____ feet & inches Weight _____ lbs Blood Pressure _____ / _____ Pulse _____ bpm

Vision: R 20/ _____ L 20/ _____ Corrected: Yes No Pupils: Equal _____ Unequal _____

Asthma _____ (Medication Used) Diabetes _____ (Medication Used) Allergies _____ (Medication Used)

MEDICAL	NORMAL	COMMENTS	INITIALS
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph nodes			
Heart/Murmurs			
Pulses			
Lungs			
Abdomen			
Skin			
Genitalia			
MUSCULOSKELETAL			
Neck			
Back/Spine			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Calf/Ankle			
Foot/Toes			
Other			

(Over)

Parent/Legal Guardian and Student to fill out BEFORE Physical Examination

Explain "Yes" answers below. Circle questions you don't know the answer to.

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	❑	❑
2. Do you have an ongoing medical condition (like diabetes or asthma)?	❑	❑
3. Are you currently taking any prescription or nonprescription (over the counter) medicines or pills?	❑	❑
4. Do you have allergies to medicines, pollens, foods or stinging insects?	❑	❑
5. Have you ever passed out or nearly passed out DURING exercise?	❑	❑
6. Have you ever passed out or nearly passed out AFTER exercise?	❑	❑
7. Have you ever had discomfort, pain or pressure in your chest during exercise?	❑	❑
8. Does your heart race or skip beats during exercise?	❑	❑
9. Has a doctor ever told you that you have: (check ALL that apply) ❑ High blood pressure ❑ A heart murmur ❑ High Cholesterol ❑ A heart infection		
10. Has a doctor ever ordered a test for your heart? (for example, ECG, echochardiogram)	❑	❑
11. Has anyone in your family died for no apparent reason?	❑	❑
12. Does anyone in your family have a heart problem?	❑	❑
13. Has any family member or relative died of heart problems or of sudden death before age 50?	❑	❑
14. Has a family member died while exercising?	❑	❑
15. Does anyone in your family have Marfan Syndrome?	❑	❑
16. Have you ever spent the night in a hospital?	❑	❑
17. Have you ever had surgery?	❑	❑
18. Have you ever had an injury, like sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, list affected area: _____	❑	❑
19. Have you had any broken or fractured bones or dislocated joints? If yes, list affected area: _____	❑	❑
20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, list affected area: _____	❑	❑
21. Have you ever had a stress fracture?	❑	❑
22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	❑	❑
23. Do you regularly use a brace or assistive device?	❑	❑
24. Has a doctor ever told you that you have asthma or wheezing?	❑	❑

	Yes	No
25. Do you cough, wheeze or have difficulty during or after exercise?	❑	❑
26. Have you ever used an inhaler or taken asthma medicine?	❑	❑
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	❑	❑
28. Have you had infectious mononucleosis (mono) within the last month?	❑	❑
29. Do you have any rashes, pressure sores, or other skin problems?	❑	❑
30. Have you ever had a herpes skin infection?	❑	❑
31. Have you ever had a head injury or concussion?	❑	❑
32. Have you been hit in the head and been confused or lost your memory?	❑	❑
33. Have you ever had a seizure?	❑	❑
34. Do you have headaches with exercise?	❑	❑
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	❑	❑
36. Have you ever been unable to move your arms or legs after being hit or falling?	❑	❑
37. When exercising in the heat, do you have severe muscle cramps, or become ill?	❑	❑
38. Do you have any hearing problems?	❑	❑
39. Do you have a hearing device?	❑	❑
40. Do you have a family member with hearing problems?	❑	❑
41. Has a doctor told you that you, or does someone in your family have sickle cell trait or sickle cell disease?	❑	❑
42. Have you had any problems with your eyes or vision?	❑	❑
43. Do you wear glasses or contact lenses?	❑	❑
44. Do you wear protective eyewear, such as goggles or a face shield?	❑	❑
45. Are you happy with your weight?	❑	❑
46. Would you like to lose weight?	❑	❑
47. Would you like to gain weight?	❑	❑
48. Has anyone recommended you change your weight or eating habits?	❑	❑
49. Do you limit or carefully control what you eat?	❑	❑
50. Do you have any concerns that you would like to discuss with a doctor?	❑	❑
51. Do you feel depressed?	❑	❑
52. Do you have a history of multiple or long nosebleeds?	❑	❑
53. **MALES ONLY:** Do you ever have or had swelling of your testicles or groin?	❑	❑
FEMALES ONLY		
54. Have you ever had a menstrual period?	❑	❑
55. How many periods have you had in the last 12 months? _____		

EXPLAIN "YES" answers here: (Add additional pages if necessary)

_____

_____

_____

I hereby verify to the best of my knowledge that the answers which have been provided to the above questions are correct.

Student's Signature _____ Parent/Legal Guardian's Signature _____ Date _____

Clearance: (Place a check in appropriate box below)

❑ Cleared for **all** sports

❑ Cleared **after** completing evaluation/rehabilitation for _____

❑ **Not** cleared for: ❑ Collision (Football)

❑ Contact (Baseball, Basketball, Cheerleading, Judo, Softball, Soccer, Volleyball, Wrestling)

❑ Non contact ❑ Strenuous ❑ Moderately Strenuous ❑ Non-strenuous

Reason not cleared _____

Physician's Recommendation _____ Date of Physical Exam _____

Physician's Name _____ Telephone _____

Address _____ Fax Number _____

Physician's Signature _____

Hawaii National Guard Youth Challenge Academy
HILO CAMPUS
PO Box 5210, Hilo, HI 96720
Phone: (808) 430-4184 Fax (808) 933-1403

Dentist

This certificate is not valid unless all fields are complete

Information (Please print)

Last Name:	**First Name:**	**Birthdate (MM/DD/YYYY)**
Parent or Guardian Name:	**Telephone (Home or Mobile)**	
Street Address:	**City and State**	
Name of High School currently attending:	**Grade:**	**Gender: ( ) Male ( ) Female**

Date of Dental Screening: _____

Treatment Needs (check ONE only based on screening results, prior to treatment services provided):

( ) NO Obvious Problems – youth's hard and soft tissues appear visually healthy and there is no apparent reason for the child to be seen before the next routine dental checkup.

( ) REQUIRES Dental Care – tooth decay or a white spot lesion is suspected in one or more teeth, or gum infection is suspected.

( ) URGENT Dental Care – obvious tooth decay is present in one or more teeth, there is evidence of injury or severe infection, or the child is experiencing pain.

Tooth decay: visible decay cavity or hole in a tooth with brown or black coloration, or a retained root.
White spot lesion: a demineralized area of a tooth, usually appearing as a chalky, white spot or white line near the gum line. It is considered as early indicator of tooth decay, especially in primary (baby) teeth.
Gum infection: Gum (gingival) tissue is red, bleeding, or swollen.

SCREENING PROVIDER (Check ONE only):

( ) DDS/DMD ( ) RDH ( ) MD/DO ( ) PA ( ) RN/ARNP

Provider Name: (please print) _____ Provider Business Phone: _____

Provider Business Address: _____

Signature and Credential of Provider or Recorder: _____

Date Signed: _____

***Recorder: An authorized provider (DDS/DMD, RDH, MD/DO, PA, RN/ARNP) may transfer information onto this form from another health document. The other health document should be attached to this form.**