August 2025

Hello WSD Families,

We wanted to make you aware that your student has qualified for an exciting opportunity that the district secured which will provide your student access to a free sports physical. A doctor from a non-profit organization in Vancouver, WA, *New Heights Clinic*, is planning to be here to facilitate sports physicals. The medical provider has current licensure in the state of Washington and serves as a volunteer health care provider on staff at New Heights Church, a 501c3 nonprofit organization.

The sports physical will be completed here in the Woodland High School nurse's office, and should only take about 15 minutes to complete. The sports physical form will be complete at the time of the exam, and a copy will be supplied to both the parents and the athletic secretary. The physical will be valid for the following two years, at which point a new physical will need to be completed. Meeting the sports requirement means your student will be cleared to participate in athletics for the next two years.

If you would like us to include your student as part of this opportunity, please complete the attached form, and return it to the school office. We will handle the scheduling and you will receive the completed physical form after the exam is complete. All exams will be completed on August 19th and August 22nd, 2025 beginning at 9:00 am.

If you have any questions, please feel free to call the office at 360.841.2804.

Thank you and we look forward to hearing from you.

Woodland High School Athletic Department

DR. PHILLIP PEARSON, PRINCIPAL • MIKE LINDSAY, ASSISTANT PRINCIPAL • TAYLOR ADRIAN, ATHLETIC DIRECTOR

WOODLAND HIGH SCHOOL • 1500 DIKE ACCESS ROAD, WOODLAND, WA 98674

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Sports Physical Permission Slip

Student Information:

- Student Name: _____
- Date of Birth: _____
- Grade Level: _____
- School Name: _____

Parent/Guardian Information:

- Parent/Guardian Name: _____
- Contact Phone Number: _____
- Email Address: _____

Consent for Sports Physical

I, _____, parent/guardian of _____, hereby consent to my child receiving a sports physical examination provided by New Heights Clinic (NHC).

I understand that the physical will be conducted by licensed healthcare professionals volunteering their time at NHC, a 501c3 nonprofit organization.

I authorize NHC to release a copy of the completed physical form to my child's school.

Emergency Contact Information In case of emergency, please contact:

- Name: _____
- Phone Number: _____

Parent Signature: _____ **Date:** _____

Please return this signed permission slip to your school

WOODLAND
Public Schools

Woodland School District 800 Second St. Woodland, WA 98674 (P)360.841.2700 (F)360.841.2701

This form should be placed into the athlete's medical file and should *not* be shared with schools or sports organizations. The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another History Form.

PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, non-binary, or another gender): _____

Have you had COVID-19? (check one): ☐ Y ☐ N

Have you been immunized for COVID-19? (check one): ☐ Y ☐ N If yes, have you had: ☐ One shot ☐ Two shots ☐ Three shots ☐ Booster date(s) _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)		Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?			
10. Have you ever had a seizure?			
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Unsure**	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		

MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease? Unsure		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		

MENSTRUAL QUESTIONS	N/A	Yes	No
29. Have you ever had a menstrual period?			
30. How old were you when you had your first menstrual period?			
31. When was your most recent menstrual period?			
32. How many periods have you had in the past 12 months?			

Explain "Yes" answers here.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

Agosto de 2025

Hola familias de WSD,

Queríamos informarle que su estudiante ha calificado para una emocionante oportunidad que el distrito aseguró, la cual le brindará acceso a un examen físico deportivo gratuito. Un médico de una organización sin fines de lucro en Vancouver, WA,*Clínica New Heights*, planea estar presente para facilitar exámenes físicos deportivos. El profesional médico tiene licencia vigente en el estado de Washington y trabaja como voluntario en la Iglesia New Heights, una organización sin fines de lucro 501c3.

El examen físico deportivo se realizará aquí, en la enfermería de la Escuela Secundaria Woodland, y sólo tomará unos 15 minutos. El formulario estará completo al momento del examen y se entregará una copia tanto a los padres como a la secretaría de deportes. El examen físico será válido por los dos años siguientes, después de los cuales será necesario realizar uno nuevo. Cumplir con el requisito deportivo significa que su estudiante estará autorizado para participar en deportes durante los próximos dos años.

Si desea que incluyamos a su estudiante en esta oportunidad, complete el formulario adjunto y devuélvelo a la secretaría de la escuela. Nos encargaremos de programar el examen y recibiremos el formulario físico completo una vez finalizado. Todos los exámenes se realizarán los días 19 y 22 de agosto de 2025 a partir de las 9:00 a. m.

Si tiene alguna pregunta, no dude en llamar a la oficina al 360.841.2804.

Gracias y esperamos saber de usted.

Departamento de Atletismo de la Escuela Secundaria Woodland

DR. PHILLIP PEARSON, PRINCIPAL • MIKE LINDSAY, ASSISTANT PRINCIPAL • TAYLOR ADRIAN, ATHLETIC DIRECTOR

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Hoja de permiso físico para deportes

Información del estudiante:

- Nombre del estudiante: _____
- Fecha de nacimiento: _____
- Nivel de grado: _____
- Nombre de la escuela: _____

Información de padres/tutores:

- Nombre del padre/tutor: _____
- Número de teléfono de contacto: _____
- Dirección de correo electrónico: _____

Consentimiento para exámen físico deportivo

Yo, _____, padre/tutor de _____, por la presente doy mi consentimiento para que mi hijo reciba un examen físico deportivo proporcionado por New Heights Clinic (NHC).

Entiendo que el examen físico será realizado por profesionales de la salud autorizados que ofrecerán su tiempo como voluntarios en NHC, una organización sin fines de lucro 501c3.

Autorizo a NHC a entregar una copia del formulario físico completo a la escuela de mi hijo.

Información de contacto de emergencia En caso de emergencia, comuníquese con:

- Nombre: _____
- Número de teléfono: _____

Firma de los padres: _____ **Fecha:** _____

Por favor devuelva esta hoja de permiso firmada a su escuela.

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Este formulario debe colocarse en el expediente médico del atleta y no debe compartirse con escuelas u organizaciones deportivas. El formulario de elegibilidad médica es el único formulario que debe enviarse a una escuela u organización deportiva.

Aviso legal: Los atletas que tengan una evaluación física de preparticipación vigente en el archivo (según los lineamientos generales estatales y locales) no necesitan completar otro formulario de antecedentes.

■ EVALUACIÓN FÍSICA PREVIA A LA PARTICIPACIÓN (orientación provisional)

FORMULARIO DE HISTORIAL CLÍNICO

Nota: Complete y firme este formulario (con la supervisión de sus padres si es menor de 18 años) antes de acudir a su cita.

Nombre: _____ Fecha de nacimiento: _____

Fecha del examen médico: _____ Deporte(s): _____

Sexo que se le asignó al nacer (F, M o intersexual): _____ ¿Con cuál género se identifica? (F, M u otro): _____

¿Ha tenido COVID-19? (elija una opción) ☐ Sí ☐ No

¿Ha recibido la vacuna contra el COVID-19? (elija una opción): ☐ Sí ☐ No Si la respuesta es sí, usted recibió: ☐ Una dosis ☐ Dos dosis ☐ Tres dosis ☐ Fecha de la dosis de refuerzo _____

Mencione los padecimientos médicos pasados y actuales que haya tenido. _____

¿Alguna vez se le practicó una cirugía? Si la respuesta es afirmativa, haga una lista de todas sus cirugías previas. _____

Medicamentos y suplementos: Enumere todos los medicamentos recetados, medicamentos de venta libre y suplementos (herbolarios y nutricionales) que consume. _____

¿Sufre de algún tipo de alergia? Si la respuesta es afirmativa, haga una lista de todas sus alergias (por ejemplo, a algún medicamento, al polen, a los alimentos, a las picaduras de insectos). _____

Cuestionario sobre la salud del paciente versión 4 (PHQ-4)

Durante las últimas dos semanas, ¿con qué frecuencia experimentó alguno de los siguientes problemas de salud? (Encierre en un círculo la respuesta)

	Ningún día	Varios días	Más de la mitad de los días	Casi todos los días
Se siente nervioso, ansioso o inquieto	0	1	2	3
No es capaz de detener o controlar la preocupación	0	1	2	3
Siente poco interés o satisfacción por hacer cosas	0	1	2	3
Se siente triste, deprimido o desesperado	0	1	2	3

(Una suma ≥3 se considera positiva en cualquiera de las subescalas, [preguntas 1 y 2 o preguntas 3 y 4] a fin de obtener un diagnóstico).

PREGUNTAS GENERALES (Dé una explicación para las preguntas en las que contestó "Sí", en la parte final de este formulario. Encierre en un círculo las preguntas si no sabe la respuesta).	**Sí**	**No**
1. ¿Tiene alguna preocupación que le gustaría discutir con su proveedor de servicios médicos?		
2. ¿Alguna vez un proveedor de servicios médicos le prohibió o restringió practicar deportes por algún motivo?		
3. ¿Padece algún problema médico o enfermedad reciente?		
PREGUNTAS SOBRE SU SALUD CARDIOVASCULAR	**Sí**	**No**
4. ¿Alguna vez se desmayó o estuvo a punto de desmayarse mientras hacía, o después de hacer, ejercicio?		

PREGUNTAS SOBRE SU SALUD CARDIOVASCULAR (*CONTINUACIÓN*)	**Sí**	**No**
5. ¿Alguna vez sintió molestias, dolor, compresión o presión en el pecho mientras hacía ejercicio?		
6. ¿Alguna vez sintió que su corazón se aceleraba, palpitaba en su pecho o latía intermitentemente (con latidos irregulares) mientras hacía ejercicio?		
7. ¿Alguna vez un médico le dijo que tiene problemas cardíacos?		
8. ¿Alguna vez un médico le pidió que se hiciera un examen del corazón? Por ejemplo, electrocardiografía (ECG) o ecocardiografía.		
9. Cuando hace ejercicio, ¿se siente mareado o siente que le falta el aire más que a sus amigos?		
10. ¿Alguna vez tuvo convulsiones?		

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Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another examination.

PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
COVID-19 VACCINE		
Previously received COVID-19 vaccine: ☐ Y ☐ N Administered COVID-19 vaccine at this visit: ☐ Y ☐ N If yes: ☐ First dose ☐ Second dose ☐ Third dose ☐ Booster date(s) _____		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA