PLACENTIA-YORBA LINDA UNIFIED SCHOOL DISTRICT - SPORTS PRE-PARTICIPATION PHYSICAL

Name _____ Age _____ ☐ Male ☐ Female

Date of Birth _____ Grade _____ School _____ School Year ☐ 20____ ☐ 20____ ☐ 20____

Check sport(s) of participation:

☐Band ☐Baseball ☐Basketball ☐Cheer ☐Color Guard ☐Cross-country ☐Dance ☐Diving ☐Football ☐Golf ☐Lacrosse ☐Song
☐Tennis ☐Soccer ☐Softball ☐Track/Field ☐Swim ☐Volleyball ☐Water Polo ☐Wrestling ☐Other _____

PARENT - Please answer questions 1-21

Has the student/athlete ever:	YES	NO
1. Been hospitalized overnight? Diagnosis		
2. Had any chronic illness? ☐ asthma ☐ diabetes ☐ frequent headaches ☐ bleeding disorder ☐Other		
3. Recently taken medication including over-the-counter meds or inhalers? Medication:		
4. Had any allergies (medication, bee stings, etc) Allergy:		
5. Become dizzy or passed out during exercise?		
6. Developed chest pain, shortness of breath or wheezing?		
7. Become tired more quickly than peers during exercise?		
8. Been told that he/she has a heart murmur or heart disease?		
9. Skipped heart beats?		
10. Had anyone in the family develop heart disease or die from heart problems under age 40?		
11. Had a significant head injury or concussion?		
12. Passed out or had a seizure?		
13. Had more than one episode of burner/stinger (pain from neck into arm)?		
14. Had heat cramps or heat exhaustion?		
15. Had a broken/fractured, sprained, or dislocated body part? List body part(s) and date(s) of injury.		
16. Is the student/athlete missing an organ or limb? List body part(s) and date(s) of loss.		
17. Does student/athlete use special equipment? ☐ Pads ☐Braces ☐Orthotics ☐Prostheses ☐Other		
18. Does student/athlete have to gain or lose weight to meet the requirements of his/her sport(s)?		
19. Does student/athlete eat a healthy well balanced diet?		
20. **For Females**: Are menses (periods): ☐ regular/monthly ☐ irregular ☐ absent		
21. Last tetanus immunization:		

I hereby authorize the use and/or disclosure of my student/athlete's individual health information for the purpose of medical clearance for participation in the district's sports program. I understand that this authorization is voluntary.

sign here _____ Student's Signature Date

sign here _____ Parent's Signature Date

PHYSICAL EXAMINATION BY PHYSICIAN

Height_____ Weight_____ BP_____

Pulse_____ Body Habitus_____

Visual Acuity:

Right eye 20/_____ Left eye 20/_____ Both eyes 20/ _____

Legend: / = within normal limits + = see comments x = omitted

General	/	+	x	General	/	+	x	Orthopedic	/	+	x	Orthopedic	/	+	x
Head				Heart				Cervical Spine/Back				Knees			
Eyes				Abdomen				Arms/Elbows/wrists/hands				Ankles/feet			
Ears/nose/throat				Genitalia/hernia				Hips				Flexibility			
Neck				Neurological											

Comments:

Discussion Items	Yes	No
Stretching emphasized		
Discussed fitness/ideal weight		
Discussed treatment of injuries		
Discussed prevention of sun/heat-related problems		
Discussed testicular cancer exams		

Medical Clearance * as appropriate for age and development	Yes	No
Full contact collision level		
Clearance deferred or no participation at this time because		

MD/DO/FNP:

State License Number:

Phone:

Address (Doctor's Stamp Required):

Date:

5/09

MUST BE TURNED IN TO THE ATHLETIC DIRECTOR OR FRONT OFFICE

PLEASE ATTACH A COPY OF THE FRONT & BACK OF HEALTH INSURANCE CARD