POWAY UNIFIED SCHOOL DISTRICT

Athletic Screening History & Physical Exam

Please indicate:

[ ] Mt. Carmel HS [ ] Poway HS [ ] Rancho Bernardo HS [ ] Westview HS

Student Name:	Student ID #:
Address:	Date of Birth:
City/Zip:	Graduating Year:
Home Phone:	Parent Name/Work Ph:
Emergency Contact/Phone:	Parent Name/Work Ph:

EXPLANATION OF SCREENING PHYSICAL

I realize that the medical evaluations performed are only screens in order to evaluate general health, to disclose existing problems, and to determine my son/daughter's dynamic ability to participate in a given sport so that obvious conditions which might be damaged or aggravated by competitive sports can be found, evaluated and treated so as to prevent further injury. This examination does not guarantee against injury.

Parent Initials _________

AWARENESS OF RISK

STUDENT AND PARENT – I am aware that playing/practicing sports can be a dangerous activity involving many risks of injury. I understand that the risks of participation include, but are not limited to, death, serious neck and spinal cord injuries that may result in complete or partial paralysis, brain damage, serious internal injury to virtually any internal organs, bones, joints, muscles, tendons, or any other aspect of the skeletal system, and serious injury or impairment to other aspects of my body, general health and well being. I understand that the risks of participation may result not only in serious injury, but in impairment of my future ability to earn a living, to engage in other business, social and recreational activities, and generally to enjoy a good life. Because of the dangers of participating in sports, I recognize the importance of following coaches' instructions regarding playing techniques, training, equipment and other team rules, etc. both in competition and practice and agree to obey such instructions.

Parent Initials _________

PERMISSION FOR TREATMENT

I hereby grant permission to the team physicians and those professional personnel designated by Poway Unified School District to treat my son/daughter in the event of an injury. In the event of a serious injury, if I am unable to give my consent at the time, this consent is to include any and all emergency procedures deemed necessary by the attending emergency personnel. I also understand that in the event of injury, every reasonable attempt will be made to contact me prior to securing medical treatment beyond basic first-aid.

Parent Initials _________

PROOF OF INSURANCE

In compliance with California Education Code 32221, I certify that there is in effect at this time insurance coverage for medical expenses resulting from bodily injury of at least $5,000 for my son/daughter, and that this coverage will remain in effect throughout the time that he/she participates in sports. I also give my permission for the above named student to participate in sports, including regularly scheduled trips by supervised school transportation.

Parent Initials _________ Insurance Carrier ________________________________ Policy # __________________________

I have read the above statements, EXPLANATION OF SCREENING PHYSICAL, AWARENESS OF RISK, and PERMISSION FOR TREATMENT, and understand them fully and agree/consent to their contents.

Parent Signature ____ Date ______________________

Student Signature ____ Date ______________________

Student Name: ____________________________

Health History - Please answer the following in the check box provided. Explain "yes" answers in the box below.

1. Have you ever been hospitalized (overnight)? [ ] Yes [ ] No
   Have you ever had surgery? [ ] Yes [ ] No
2. Are you currently taking medication? [ ] Yes [ ] No
3. Do you have any allergies (medicines, pollen, bees)? [ ] Yes [ ] No
4. Have you ever passed out during exercise? (not from heat) [ ] Yes [ ] No
   Have you ever been dizzy during exercise? (not from heat) [ ] Yes [ ] No
   Have you ever had chest pain? [ ] Yes [ ] No
   Do you tire more quickly than your friends during exercise? [ ] Yes [ ] No
   Have you ever had high blood pressure? [ ] Yes [ ] No
   Have you ever been told you had a heart murmur? [ ] Yes [ ] No
   Have you ever had racing of your heart or skipped beats? [ ] Yes [ ] No
   Has anyone in your family died of heart problems or a
   sudden death before age 40? [ ] Yes [ ] No
   Does anyone in your family have Marfan's Syndrome? [ ] Yes [ ] No
5. Do you have any skin problems (itching, rashes, breaking out)? [ ] Yes [ ] No
6. Have you ever had a head injury? [ ] Yes [ ] No
   Have you ever been knocked out? [ ] Yes [ ] No
   Have you ever had a seizure? [ ] Yes [ ] No
   Have you ever had a burner/stinger? (pain from neck to arm) [ ] Yes [ ] No
7. Have you ever had heat cramps? [ ] Yes [ ] No
   Have you ever been dizzy or passed out in the heat? [ ] Yes [ ] No
8. Do you use special pads or braces? [ ] Yes [ ] No
9. Have you ever injured (broken/fractured, sprained, dislocated):
   [ ] Hand/fingers [ ] Shoulder [ ] Hip [ ] Shin/calf
   [ ] Wrist/forearm [ ] Neck [ ] Thigh [ ] Ankle
   [ ] Elbow [ ] Chest/ribs [ ] Knee [ ] Foot/toes
   [ ] Upper arm [ ] Back [ ] Stress fractures? ________________________
10. Have you ever had:
    [ ] Mononucleosis [ ] Diabetes [ ] Measles [ ] Hernia(s)
    [ ] Hepatitis [ ] Headaches (frequent) [ ] Asthma [ ] Ulcers
    [ ] Eye/ear injuries [ ] Tuberculosis [ ] Sickle cell trait/disease
11. When was your last tetanus shot? ____________________
12. About your weight: Do you think you are… [ ] just right? [ ] too heavy? [ ] too light/thin?
    Do you like to drink dairy (milk) products? [ ] Yes [ ] No
    For females:
    When was your first period and how old were you? _______________________
    When was your last period? ____________________
    Are your periods… [ ] Regular/monthly? [ ] Irregular/skip months?

15. **Please ask the doctor to address any questions that you may have. [All discussions are kept confidential.]**

Please explain any "yes" answers here:

16. Circle the sports you will be participating in:

Baseball	Football	Soccer	Tennis
Basketball	Golf	Softball	Volleyball
Cheerleading	Gymnastics	Swimming	Water Polo
Cross Country	Lacrosse	Track/Field	Wrestling
Field Hockey	Other (s)		

Physical Examination

(To be completed by Medical Personnel)

Height _______

Weight _______

Body fat _______% (optional)

Blood Pressure _______ (sitting, left arm)

Pulse _______

Vision (optional)
Left eye 20/ ____
Right eye 20/ ____
Both eyes 20/ ____
with / without glasses

1. Skin	
2. Head	
3. Eyes (PERLA, EOMI, Fundi)	
4. Ears, nose, throat	
5. Neck	
6. Lymphatics	
7. Respiratory	
8. Cardiovascular	
Heart (murmurs?)	
9. Abdomen	
10. Genitalia (include. hernia exam – optional)	
11. Extremities	
12. Neurologic	
Reflexes	
13. Orthopedic	
Cervical spine/back	
Arms/elbows/wrist/hands	
Hips	
Knees	
Ankles/feet	
14. Developmental	
Tanner staging 1 – 5 (optional)	

√ = within normal limits
+ = see comments
X = omitted

Comments/Recommendations:

Medical Clearance

(As appropriate for age and development)

Please indicate:

[ ] Full, unrestricted participation

OR

[ ] Clearance deferred or no participation at this time because:

[ ] Needs to complete rehabilitation for current condition(s) prior to participation
Notes: ____________________________________

[ ] Needs clearance by specialist:
[ ] Orthopedist [ ] Cardiologist

[ ] Other:

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Physician's Statement:

(Student's name) ___________________ was examined by me on (date) _____________ and found physically fit to engage in high school athletics. Results are to encourage, but in no way guarantee, the fitness and safety of this athlete.

Practitioner Signature: _____________________________________ Date ____________
M.D. / D.O. / N.P. / P.A. / D.C.

Physician's Office Stamp HERE