

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? <input type="checkbox"/> asthma <input type="checkbox"/> diabetes <input type="checkbox"/> frequent headaches <input type="checkbox"/> bleeding disorder <input type="checkbox"/> 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? <input type="checkbox"/> Pads <input type="checkbox"/> Braces <input type="checkbox"/> Orthotics <input type="checkbox"/> Prostheses <input type="checkbox"/> 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): <input type="checkbox"/> regular/monthly <input type="checkbox"/> irregular <input type="checkbox"/> 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.

Student's Signature

Date

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/PA

State License Number:

Phone:

Address (Doctor's Stamp Required):

Date:

Must be turned in to the School's Front Office