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

 Been hospitalized overnight? Diagnosis Had any chronic illness? ☐ asthma ☐ diabetes ☐ frequent headaches ☐ bleeding disorder ☐ Other Recently taken medication including over-the-counter meds or inhalers? Medication: 	⊒Song	□Son
Baseball Baseball Cheer Color Guard Cross-country Dance Diving Football Golf Lacrosse Initial Color		
Has the student/athlete ever:		
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1. Been hospitalized overnight? Diagnosis 2. Had any chronic illness? ashma 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 litred 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 heart 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 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 have to gain or lose weight to meet the requirements of his/her sport(s)? 19. Does student/athlete at a healthy well balanced diet? 20. For Females: Are menses (periods): regular/monthly irregular absent 21. Last tetanus immunization: Ihereby authorize the use and/or disclosure of my student/athletes individual health information for the purpose of medical clearance for part district's Storts program. Lunderstand that this authorization is voluntary. Student's Signature Date Parent's Signature Parent's Signatur	ES	YES
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Must be turned in to the School's Front Office