

# 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  Soccer  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 \_\_\_\_\_ Visual Acuity:  
 Pulse \_\_\_\_\_ Body Habitus \_\_\_\_\_ 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	Medical Clearance * as appropriate for age and development	Yes	No
Stretching emphasized			Full contact collision level		
Discussed fitness/ideal weight			Clearance deferred or no participation at this time because		
Discussed treatment of injuries					
Discussed prevention of sun/heat-related problems					
Discussed testicular cancer exams					

MD/DO/FNP:	State License Number:	Phone:
Address (Doctor's Stamp Required):		Date: