

**SHASTA UNION HIGH SCHOOL DISTRICT
Athletics Health Screening Examination Record**

Health Screening Examination
(to be completed and signed by a physician)

Student Name _____ Date of Birth _____ Telephone # _____
 Age: _____ Gender: _____ Height: _____ Weight: _____
 Pulse Rate: _____ Blood Pressure: _____

Health History

(to be completed and signed by parent/guardian)

Has your child ever had or does he/she now have any of the following?
 (Please explain any yes answers)

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic or recurrent illnesses _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Illnesses lasting more than a week _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hospitalizations _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgery, other than tonsillectomy _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Problem with blood pressure or heart _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness, fainting or frequent headaches _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Ever been knocked out or had a concussion or lost memory _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck/back injury or surgery, numbness or tingling in arms, hands, legs or feet _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | A stinger, burner or pinched nerve? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Knee, ankle injury or surgery _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other joint sprains or dislocation, pain or swelling _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Broken bones (fractures) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy or seizure disorder _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma or shortness of breath _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Illness from exercising in the heat _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Nervous disorder or mental illness _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Currently taking any medications _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergic to any medications (aspirin, penicillin, etc.) or bee stings _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Wear eyeglasses or contact lenses _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Wear dental appliances, orthotics or prosthetic equipment _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Desire to weigh more or less than current weight. Lose weight regularly to meet weight requirements for sports _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Stressed out feeling _____ |

Please use this space to further explain the above answers or for additional information:

Parent/Guardian Permission and Release

I declare that the above information is correct to the best of my knowledge. I understand this is a screening examination to determine if any obvious medical problems exist to prevent my child from participating in school athletic events. This examination is not a complete medical examination. You should contact your family physician for your medical needs. If any medical problems are identified in this screening examination, further examination and treatment should be obtained through your physician.

Parent/Guardian Signature _____ Date _____

	Normal	Abnormal	Comments
Eyes/Ears/Nose/Throat			
Lymph nodes			
Heart			
Lungs			
Abdomen			
Genitalia/Hernia (males only)			
Skin			
Neck/Spine			
Arms/Shoulders/Elbows			
Wrists/Hands			
Legs/Hips/Thighs/Knees			
Ankles/Feet			

Based on this history and physical exam the following ABNORMALITIES were found and need further evaluation before clearance for competitive athletics:

- _____
- _____
- _____

Recommendations:

- CLEARED - There were no history or physical findings on this exam which would prohibit this student from participating in competitive athletics.
- This student should have the above health problems evaluated or treated PRIOR to participating in competitive athletics.
- This student has health problems which would PROHIBIT him or her from participating in competitive athletics.

Physician Name (print/type) _____ Phone _____
 Physician Signature _____ Date _____