ALL PHYSICALS MUST HAVE AN OFFICIAL STAMP FROM YOUR DOCTORS OFFICE!

Current Grade: 9 10 11 12

CENTER UNIFIED SCHOOL DISTRICT
Athletics Health Screening Examination Record

Student Name _____ Date of Birth _____ Telephone # _____

Age: _____ Gender: _____ Height: _____ Weight: _____

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?

	Yes	No		(Please explain any yes answers)
1.	☐	☐	Chronic or recurrent illnesses	
2.	☐	☐	Illnesses lasting more than a week	
3.	☐	☐	Hospitalizations	
4.	☐	☐	Surgery, other than tonsillectomy	
5.	☐	☐	Problem with blood pressure or heart	
6.	☐	☐	Dizziness, fainting or frequent headaches	
7.	☐	☐	Ever been knocked out or had a concussion or lost memory	
8.	☐	☐	Neck/back injury or surgery, numbness or tingling in arms, hands, legs or feet	
9.	☐	☐	A stinger, burner or pinched nerve?	
10.	☐	☐	Knee, ankle injury or surgery	
11.	☐	☐	Other joint sprains or dislocation, pain or swelling	
12.	☐	☐	Broken bones (fractures)	
13.	☐	☐	Epilepsy or seizure disorder	
14.	☐	☐	Asthma or shortness of breath	
15.	☐	☐	Diabetes	
16.	☐	☐	Illness from exercising in the heat	
17.	☐	☐	Nervous disorder or mental illness	
18.	☐	☐	Currently taking any medications	
19.	☐	☐	Allergic to any medications (aspirin, penicillin, etc.) or bee stings	
20.	☐	☐	Wear eyeglasses or contact lenses	
21.	☐	☐	Wear dental appliances, othotics or prosthetic equipment	
22.	☐	☐	Desire to weigh more or less than current weight. Lose weight regularly to meet weight requirements for sports	
23.	☐	☐	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**

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

Pulse Rate: _____ Blood Pressure: _____

	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:

1. _____
2. _____
3. _____

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**

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