Current School ____________

Current Grade 8 9 10 11 12

SHASTA UNION HIGH 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? (Please explain any yes answers)

	Yes	No	
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**