Elk Grove Unified School District

2025-2026

Risk Management Department

DAIM NTAWV KUAJ IB CE RAU KEV UA KISLAS

FEEM 1 (QHOV NO YUAV TSUM TAU MUAJ UA KOM TIAV LOS NTAWM NIAMTXIV LOSSIS TUS SAIBXYUAS)

LUB XEEM	NPE		QIB KAWM

HNUB YUG	KISLAS THAUM LUB CAIJ (FALL)	KISLAS THAUM LUB CAIJ NTUJ NO	KISLAS THAUM LUB CAIJ (SPRING)	TUB NTXHAIS TUS LEJ ID#

FEEM 1 – KEEBKWM TXOG KEV NOJ QAB HAUS HUV (Yuav tsum tau muab qhov no ua kom tiav los ntawm Niamtxiv/Tus Saibxyuas Uantej Kuaj ib Ce)

	Muaj	No	Has this student had:
1.	☐	☐	Chronic or recurrent illness?
2.	☐	☐	Illness lasting over 1 week?
3.	☐	☐	Hospitalizations or Surgeries?
4.	☐	☐	Nervous, psychiatric, or neurologic condition?
5.	☐	☐	Loss or nonfunctioning of organs (eye, kidney, liver, testicle) or glands?
6.	☐	☐	Allergies (medicines, insect bites, food)?
7.	☐	☐	Problems with heart or blood pressure?
8.	☐	☐	Chest pain or significant or severe shortness of breath during or after exercise?
9.	☐	☐	Dizziness or fainting with exercise?
10.	☐	☐	Fainting, bad headaches or convulsions?
11.	☐	☐	Potential concussion or loss of consciousness?
12.	☐	☐	Heat exhaustion, heatstroke, or other problems managing or responding to heat?
13.	☐	☐	Racing heartbeat, skipped or irregular heartbeats, or heart murmur?
14.	☐	☐	Seizures or seizure disorders?
15.	☐	☐	Severe or repeated instances of muscle cramps?
16.	☐	☐	Injuries requiring medical care or treatment?
17.	☐	☐	Neck or back pain or injury?
18.	☐	☐	Knee pain or injury?
19.	☐	☐	Shoulder or elbow pain or injury?
20.	☐	☐	Ankle pain or injury?
21.	☐	☐	Other joint pain or injury?
22.	☐	☐	Broken bones (fractures)?
	Yes	**No**	**Does this student presently:**
23.	☐	☐	Wear eyeglasses or contact lenses?
24.	☐	☐	Wear dental bridges, braces or plates?
25.	☐	☐	Take any medications? (List below):
	Yes	**No**	**Further history:**
26.	☐	☐	Birth defects (corrected or not)?
27.	☐	☐	Death of a parent or grandparent less than 40 years of age due to medical cause or condition?
28.	☐	☐	Parent or grandparent requiring treatment for heart condition less than 50 years of age?
29.	☐	☐	Been seen by a physician on an emergency or urgent basis in the last 12-months?

Zaum kawg uas txhaj koob tshuaj tetanus (lockjaw): _____ *Zaum kawg uas tau mus kuaj ib ce:* _____

Qhia txhua qhov uas koj tau teb "YES". Qhia tej yam uas muaj tseeb uas yuav tsum tau qhia uantej kuaj ib ce (sau rau sab nraud daim ntawv no yog hais tias tsi txaus):

NIAMTXIV/TUS SAIBXYUAS KEV TSO CAI: Kuv tso cai rau kws khomob kuaj kuv tus tub ntxhais ib ce rau kev ua kislas. Cov kev qhia saum toj no yeej qhia tas tas thiab muaj tseeb. Kuv yeej tsi pom muaj dabtsi uas yuav los tabkaum tau tus tub ntxhais kev yuav ua cov kislas li tau muab teev tseg no. Kev kuaj ib cev rau kev ua kislas no tejzaum yuav raug kuaj los ntawm lub District cov neeg uas tuam yeem tuaj pab ua haujlwm pub dawb xwb, Kuv totaub hais tias kev kuaj tsuas yog kuaj xwb, kuv yuav tsum tau hais qhia tej kev txhawjxeeb txog mob nkees rau kuv tus tub ntxhais tus kws khomob.

SAU UA TEJ TUS NTSIAJ NTAWV NIAMTXIV LOSSIS TUS SAIBXYUAS NPE	NIAMTXIV LOSSIS TUS SAIBXYUAS XEES NPE	

CHAW NYOB	XOVTOOJ TOM HAUJLWM	XOVTOOJ TOM TSEV	HNUB

REGULAR PHYSICIAN'S NAME	OFFICE PHONE	**PROVIDER CLINIC OR ORGANIZATION**

PART 2 – MEDICAL EVALUATION (TO BE COMPLETED BY THE EXAMINING HEALTH CARE PROVIDER)

This Evaluation Can Only be Performed by Medical Doctors (MDs), Doctors of Osteopathy (DOs), Physician's Assistants (P.A.s), and Nurse Practitioners (N.P.s)

	NORMAL	ABNORMAL (Describe)
Eyes/Ears/Nose/Throat		
Heart, lungs, pulmonary function		
Abdomen, genital/hernia (males)		
Skin and Musculoskeletal:		
a. Neck/Spine/Shoulders/Back		
b. Arms/Hands/Fingers		
c. Hips/Thighs/Knees/Legs		
d. Feet/Ankles		
Neurologic Screening Exam (NSE)/ Concussion Screening Evaluation (only if needed based on above info.)		
Comments:		

(May be contained on Provider's Form)

Height: Weight:

Pulse: After Ex:

BP:

Recommendation:

☐ Unlimited participation

☐ Limited participation/specific sports, events or activities

☐ Clearance withheld pending further testing/evaluation No athletic participation

One of the above MUST be checked.

PHYSICIAN STAMP

PRINT NAME OF PHYSICIAN | PHYSICIAN'S SIGNATURE | DATE

[(Ed. 12/1/11)Rev:12/8/11)

Original to be held on file with the Athletic Director for a period of one (1) year after the end of the Academic Year.