

SAN LEANDRO HIGH SCHOOL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

Every year each student (grades 9-12) shall present to the student's athletic director or coach a certificate signed by a licensed physician and surgeon, osteopathic physician and surgeon, osteopath, advanced registered nurse practitioner (ARNP), physician's assistant or qualified doctor of chiropractic, to the effect that the student has been examined and may safely engage in athletic competition.

This certificate of physical examination is valid for the purposes of this rule for one (1) calendar year.

QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (Please type or neatly print this information)

Name _____ Male ___ Female ___ Date of Birth _____ Grade _____

Home Address _____ Phone # _____

Parent's/Guardian's Name _____ Date _____

Family Physician _____ Phone# _____

HEALTH HISTORY (The following questions should be completed by the student-athlete with the assistance of a parent or guardian. A parent or guardian is required to sign on the back of this form after the physical examination is completed.)

YES NO Has this student had any?

- 1. _____ Chronic or recurrent illness or injury?
- 2. _____ Any illness lasting more than one (1) week?
- 3. _____ Rheumatic fever, mononucleosis?
- 4. _____ Hospitalizations (Overnight or longer)?
- 5. _____ Surgery, other than tonsillectomy?
- 6. _____ Missing organs (eye, kidney, testicle)?
- 7. _____ Allergy to medications, insects, food?
- 8. _____ Seasonal allergies (hay fever)?
- 9. _____ Problems with heart, blood pressure, cholesterol?
- 10. _____ Racing of your heart or skipped heart beats?
- 11. _____ Chest pain with exercise?
- 12. _____ Frequent headaches, convulsions, dizziness, fainting?
- 13. _____ Dizziness or fainting with exercise?
- 14. _____ Concussion, unconsciousness, extremity numbness?
- 15. _____ Heat exhaustion, heat stroke, heat related problems?

YES NO Has this student had any?

- 16. _____ Asthma?
- 17. _____ Epilepsy or other seizures?
- 18. _____ Diabetes?
- 19. _____ Eyeglasses or contact lenses?
- 20. _____ Dental braces, bridges, plates?

YES NO Is there a history of?

- 21. _____ Injuries requiring medical treatment?
- 22. _____ Neck injury?
- 23. _____ Knee injury?
- 24. _____ Knee surgery?
- 25. _____ Ankle injury?
- 26. _____ Broken bones (fractures)?
- 27. _____ Other serious joint injuries?
- 28. _____ Use of protective equipment or braces?

YES NO Further History:

- 29. _____ Is there a history of family or genetic disease?
- 30. _____ Has any family member died suddenly at less than 40 years of age of causes other than an accident?
- 31. _____ Has any family member had a heart attack at less than 55 years of age?
- 32. _____ Are you uncomfortably short of breath after running ½ mile (2 times around a track) without stopping?

Use this space to explain any of the above numbered YES answers or to provide additional information:

33. List all medications you are presently taking, including asthma inhalers, and the condition the medication is for:

A. _____ B. _____ C. _____

34. What is the most and least you have weighed in the past year? **Most** _____ **Least** _____

PHYSICAL EXAMINATION RECORD (To be completed by a licensed professional as designated in Article VII 36.14(1). This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations.)

Athlete's Name _____

Height _____ Weight _____ Pulse _____ Blood Pressure _____ Vision R 20/ _____ L 20/ _____

	NORMAL	ABNORMAL FINDINGS	INITIALS
1. Appearance (esp. Marfan's)	_____	_____	_____
2. Eyes/Ears/Nose/Throat	_____	_____	_____
3. Mouth & Teeth	_____	_____	_____
4. Neck	_____	_____	_____
5. Lymph Nodes	_____	_____	_____
6. Heart (Standing & Lying)	_____	_____	_____
7. Pulses (esp. femoral)	_____	_____	_____
8. Chest & Lungs	_____	_____	_____
9. Abdomen	_____	_____	_____
10. Skin	_____	_____	_____
11. Musculoskeletal - ROM, Strength, etc. (See questions 21-28)	_____	_____	_____
12. Neurological	_____	_____	_____
13. Flexibility	_____	_____	_____

Comments regarding abnormal findings:

ATHLETIC PARTICIPATION RECOMMENDATIONS

_____ **FULL & UNLIMITED PARTICIPATION**

_____ **LIMITED PARTICIPATION** - May NOT participate in the following (checked):

- Baseball Basketball Cross Country Football Golf Soccer
 Softball Swimming Tennis Track Volleyball Wrestling

_____ **CLEARANCE PENDING DOCUMENTED FOLLOW UP OF** _____

_____ **NOT CLEARED FOR ATHLETIC PARTICIPATION**

 Licensed Medical Professional's Name (Printed) _____ Date _____

 Licensed Medical Professional's Signature _____ Phone _____

Parent's or Guardian's Permission and Release (Sign after the physical examination has been completed.)

I hereby give my consent for the above named student to engage in approved athletic activities as a representative of his/her school, except those activities indicated above by the licensed professional. I also give my permission for the team's physician, athletic trainer, or other qualified personnel to give first aid treatment to my son or daughter at an athletic event in case of injury.

 Typed or printed Name of Parent or Guardian

 Signature of Parent of Guardian

 Address (Street/PO Box, City, State, Zip)

 Phone Number