# GRANADA HILLS CHARTER HIGH SCHOOL
# HEALTH HISTORY

**This side to be completed and signed by parent and student Opposite side to be completed, signed and stamped by MD,DO,NP or PA. Completed form to be emailed to healthphysicals@ghctk12.com at least 48 hours prior to tryouts**

Name:_____ Sex:_____ Age:_____ Date of Birth: _____

Grade:_____ STUDENT ID# :_____ Sport(s): _____

Address:_____ Phone: (_____)_____

Personal Physician/Provider_____

**Explain "Yes" answers below.**

| | Yes | No |
|---|---|---|
| 1. Do you think you are in good health? | ☐ | ☐ |
| 2. Do you have an ongoing medical condition? (ex: diabetes or asthma) | ☐ | ☐ |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills? | ☐ | ☐ |
| 4. Do you have any allergies to medicines, pollens, foods, or stinging insects? | ☐ | ☐ |
| 5. Has a physician ever denied or restricted your participation in sports for any reason? | ☐ | ☐ |
| 6. Have you ever passed out or nearly passed out DURING exercise? | ☐ | ☐ |
| 7. Have you ever passed out or nearly passed out AFTER exercise? | ☐ | ☐ |
| 8. Have you ever had discomfort, pain, or pressure in your chest during exercise? | ☐ | ☐ |
| 9. Does your heart race or skip beats during exercise? | ☐ | ☐ |
| 10. Has a doctor ever told you that you have (circle all that apply) High Blood Pressure, A Heart Murmur, High Cholesterol, A Heart Infection | | |
| 11. Has a doctor ever ordered a test for your heart? Example: ECG, echocardiogram | ☐ | ☐ |
| 12. Has anyone in your family died for no apparent reason? | ☐ | ☐ |
| 13. Does anyone in your family have a heart problem? | ☐ | ☐ |
| 14. Has any family member or relative died of heart problems or of sudden death before age 50? | ☐ | ☐ |
| 15. Does anyone in your family have Marfan syndrome? | ☐ | ☐ |
| 16. Have you ever spent the night in a hospital? | ☐ | ☐ |
| 17. Have you ever had surgery? | ☐ | ☐ |
| 18. Have you ever had an injury, like a sprain, muscle, ligament tear, or tendinitis that caused you to miss a practice or game? If yes, circle affected area below: | ☐ | ☐ |
| 19. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: | ☐ | ☐ |
| 20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitations, physical therapy, abrace, a cast or crutches? If yes, circle below: Head Neck Shoulder Upper Arm Elbow Chest Hand/Fingers Forearm Ankle Foot/Toes Upper Back Lower Back Hip Thigh Knee Calf/Shin | ☐ | ☐ |
| 21. Have you ever had a stress fracture? | ☐ | ☐ |
| 22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| 23. Do you regularly use a brace or assistive device? | ☐ | ☐ |
| 24. Has a doctor ever told you that you have asthma or allergies? | ☐ | ☐ |
| 25. Do you cough, wheeze, or have difficulty breathing during or after exercise? | ☐ | ☐ |
| 26. Is there anyone in your family who has asthma? | ☐ | ☐ |
| 27. Have you ever used an inhaler or taken asthma medicine? | ☐ | ☐ |
| 28. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | ☐ | ☐ |
| 29. Have you had infectious mononucleosis within the last month? | ☐ | ☐ |
| 30. Do you have any rashes, pressure sores, or other skin problems? | ☐ | ☐ |
| 31. Have you had a herpes skin infection? | ☐ | ☐ |
| 32. Have you had any problems with your eyes or vision? | ☐ | ☐ |
| 33. Do you wear glasses or contact lenses? | ☐ | ☐ |
| 34. Do you wear protective eyewear, such as goggles or a face shield? | ☐ | ☐ |
| 35. Are you happy with your weight? | ☐ | ☐ |
| 36. Are you trying to gain or lose weight? | ☐ | ☐ |
| 37. Has anyone recommended you change your weight or eating habits? | ☐ | ☐ |
| 38. Do you limit or carefully control what you eat? | ☐ | ☐ |
| 39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | ☐ | ☐ |
| 40. Have you ever had a head injury or concussion? | ☐ | ☐ |
| 41. Have you been hit in the head and been confused or lost your memory? | ☐ | ☐ |
| 42. Have you ever had a seizure? | ☐ | ☐ |
| 43. Do you have headaches with exercise? | ☐ | ☐ |
| 44. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | ☐ | ☐ |
| 45. Have you ever been unable to move your arms or legs after being hit or falling? | ☐ | ☐ |
| 46. When exercising in the heat, do you have severe muscle cramps or become ill? | ☐ | ☐ |
| 47. Do you have any concerns that you would like to discuss with a doctor? | ☐ | ☐ |

FEMALES ONLY

| | | |
|---|---|---|
| 48. Have you ever had a menstrual period? | ☐ | ☐ |
| 49. How old were you when you had your first menstrual period? | _____ | |
| 50. How many periods have you had in the last 12 months? | _____ | |

**Explain "Yes" Answers Here:** _____

_____

_____

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

**Signature of athlete**_____ **Date:**_____

**Signature of parent/guardian**_____ **Date:** _____

# PHYSICAL EXAMINATION FOR INTERSCHOLASTIC ATHLETICS

**NAME**_____ **Student ID#**_____ **Date of Birth**_____

Height_____Weight_____BMI (optional)_____Pulse_____BP_____/____(_____/____,_/____)

Vision: R 20/____L 20/____ Corrected: Yes No Pupils: Equal_____ Unequal _____

**EMERGENCY INFORMATION**
**Allergies/Other:** _____

| | Normal | Abnormal Findings | Initials* |
|---|---|---|---|
| **MEDICAL** | | | |
| Appearance | | | |
| Eyes/Ears/Nose/Throat | | | |
| Lymph Nodes | | | |
| Heart | | | |
| Pulses | | | |
| Lungs | | | |
| Abdomen | | | |
| Genitalia (males only) | | | |
| Skin | | | |
| **MUSCULOSKELETAL** | | | |
| Neck | | | |
| Back | | | |
| Shoulder/arm | | | |
| Elbow/forearm | | | |
| Wrist/hand | | | |
| Hip/thigh | | | |
| Knee | | | |
| Leg/ankle | | | |
| Foot | | | |

Date of last Tdap booster:_____ Varicella Documentation: _____

## CLEARANCE

❑ Cleared without restriction

❑ Cleared, with recommendations for further evaluation or treatment for:_____

❑ Not cleared for: ❑ All Sports ❑ Certain Sports: _____

Name of Physician/Provider: (print/type/stamp)_____( MD, DO, NP or PA)

Address:_____Phone: _____

Signature of Physician: _____

Date of Exam: _____

**MEDICAL OFFICE STAMP (Required)**

**THIS EXAM MUST HAVE A STAMP, SIGNATURE, VISUAL ACUITY & DATE OF EXAM**