**C.I.F. ATHLETIC PARTICIPATION HEALTH FORM**

SANTA BARBARA UNIFIED SCHOOL DISTRICT

HEALTH SERVICES

**STUDENT INFORMATION is to be completed by student-PARENT SIGNATURE REQUIRED**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **LAST/APELLIDO FIRST/PRIMERO**

**ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **STREET CITY ZIP PHONE NUMBER**

**HISTORY:**

1. Have you had - (circle IF YES) allergies, asthma, seizures, heart murmur, a broken bone, diabetes, surgery or hospitalization: Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you wear corrective lenses during sports? YES\_\_\_\_\_\_\_\_\_\_\_\_ Glasses or Contacts NO\_\_\_\_\_\_\_\_\_\_\_\_
3. Is your hearing normal? YES\_\_\_\_\_\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_\_\_\_\_\_
4. Do you take any medications? YES\_\_\_\_\_\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_\_\_\_\_\_ If YES, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Please note any other medical information that school personnel may need to know: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Permission for EXAM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ORIGINAL MUST BE RETURNED TO SCHOOL**

**PHYSICAL EXAMINATION**

**(MUST** be completed by MD, DO, PA, or NP)

Exam Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_\_\_ BP:\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ Pulse: \_\_\_\_\_\_\_\_\_\_\_\_

**CODE: 0 = Negative X = Positive NE = No Examination**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Ears, Nose, Throat |  |  8. Musculoskeletal Evaluation |  |
| 2. Eyes - Pupil Equal Reactive |  | 8.1 Flexibility/Stability of Joints |  |
|  Symmetry of Eye Movement |  |  Gait Hand  |  |
| 3. Dental - Missing Teeth |  |  Kneebend |  |
|  Chipped Teeth |  | 8.2 Spine - Scoliosis |  |
|  Removable Teeth |  | 8.3 Swelling of Joints  |  |
|  Orthodontia |  | 8.4 Muscular Weakness |  |
| 4. Lungs |  | 8.5 Atrophy  |  |
| 5. Heart |  |  Thigh Shoulder Girdle  |  |
| 6. Abdomen |  |  Calf Arm |  |
| 7. Hernia |  | 9. Incoordination/Loss of Balance  |  |

Additional findings, comments and/or recommendations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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“I certify that I have on this date examined this student and that on the basis of the exam requested by the school authorities and the student’s medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities.”

**IF STUDENT IS NOT MEDICALLY FIT TO PARTICIPATE IN ATHLETICS OR IF THERE ARE EXCEPTIONS TO THE ABOVE STATEMENT, EXAMINING PHYSICIAN SHOULD INDICATE ABOVE.**

Signature of Examining Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_