Fremont Union High School District

Physical Exam Form - Part 1

Student/Athlete's Health History (Required)

School: _____ School Year: _____ Sports/Activities Trying Out for: _____

Last Name: _____ First Name: _____ M.I.: _____ ☐ Male ☐ Female

Grade: _____ Home Ph: _____ Date of Birth: _____ Age: _____

Home Address: _____ City: _____ Zip: _____

Name of Family Doctor or Medical Clinic/Hospital: _____

Street Address of Doctor or Medical Clinic/Hospital: _____

City: _____ Zip: _____ Doctor's Office Phone Number: _____

STUDENT'S HEALTH HISTORY: To be completed by the Parent/Guardian and reviewed by the doctor at time of the student's Physical Exam. Parents, please check (√) "Yes" or "No" to the questions below about your child's health history.

Date of student's last Diphtheria/Tetanus shot? (month/day/year) _____

Has the student had any:	Yes	No
1. Chronic or recurrent illness?	☐	☐
2. Illness lasting over 1 week?	☐	☐
3. Hospitalization?	☐	☐
4. Surgery other than removal of tonsils?	☐	☐
5. Missing organs (eye, kidney, testicle)?	☐	☐
6. Problems with heart or shortness of breath during exercise?	☐	☐
7. Dizziness or fainting with exercise?	☐	☐
8. Fainting, bad headaches, or convulsions?	☐	☐
9. Concussion or loss of consciousness?	☐	☐
10. Heat exhaustion, heatstroke, or other problems with heat?	☐	☐
Does this student:		
11. Wear eyeglasses or contact lenses?	☐	☐
12. Wear dental bridges, braces, or plates?	☐	☐
13. Take any medications? If so, please list them below.	☐	☐

Is there any history of:	Yes	No
14. Injuries requiring Doctor's treaments?	☐	☐
15. Neck or back injury?	☐	☐
16. Knee injury?	☐	☐
17. Shoulder or elbow injury?	☐	☐
18. Ankle injury?	☐	☐
19. Other serious joint injury?	☐	☐
20. Broken bones or fractures?	☐	☐
21. Other serious injury?	☐	☐
Further History:		
22. Is there any reason why this student should participate in sports?	☐	☐
23. Has any family member died suddenly at less than 40 years of age of causes other than an accident?	☐	☐
24. Has any family member had a heart attack at less than 35 years of age?	☐	☐

Use the space below to explain any questions above that you answered "yes" to:

Medications your son/daughter is currently taking:

Parent's/Guardian's & Student's Acknowledgement

I have reviewed and agree with the information presented on this form. I also understand that the Physical Examination is primarily for sports participation screening and is not intended to replace the routine health care visits as recommended by the student's personal doctor. I do not know of any reason why the above-named student should not participate and represent his/her school in supervised athletic activities.

Signature of Parent/Guardian: _____ Date (mo/day/year): _____

Signature of Student/Athlete: _____ Date (mo/day/year): _____

Fremont Union High School District

Physical Exam Form - Part 2
Physical Examination Form (Required)

A medical doctor (an MD, not a chiropractor) must administer this Physical Exam & sign/date below.

Parents - Please complete the top line for the doctor and please print neatly. All other areas will be completed by the doctor.

Last Name: _____ First Name: _____ M.I.: _____ Date of Birth: _____ School: _____

Height: _____ Weight: _____ % Body Fat (optional) _____ Pulse: _____ BP: _____ (____/____, ____/____)

Vision: R - 20/ _____ **L - 20/** _____ **Corrected: Y☐N☐ Pupils: Equal** _____ **Unequal** _____

Follow-up Questions on More Sensitive Issues - Questions asked by the doctor	**Yes**	**No**
1. Do you feel stressed out or under a lot of pressure?	☐	☐
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?	☐	☐
3. Do you feel safe?	☐	☐
4. Have you ever tried cigarette smoking, even 1 or 2 puffs?	☐	☐
5. Do you currently smoke?	☐	☐
6. During the past 30 days, have you used chewing tobacco, snuff, or dip?	☐	☐
7. During the past 30 days, have you had at least one drink of alcohol?	☐	☐
8. Have you ever taken steroid pills or shots without a doctor's prescription?	☐	☐
9. Have you ever taken any supplements to help you gain or lose weight or improve your performance?	☐	☐
Does this student:		
10. Wear eyeglasses or contact lenses?	☐	☐
11. Wear dental bridges, braces, or plates?	☐	☐
12. Take any medications? If so, please list them below.	☐	☐

Dr.'s Notes: _____

DOCTOR'S EXAMINATION	**NORMAL**	**ABNORMAL FINDINGS** (Doctor, please list & describe any abnormalities)
Appearance		
Eyes/ears/nose/throat		
Hearing		
Lymph Nodes		
Heart		
Mummurs		
Pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hips/thigh		
Knee		
Leg/ankle		
Foot/toes		

*Multiple-examiner set-up only. **Having a third party present is recommended for the genitourinary examination.*

DOCTOR'S CLEARANCE: This student is medically cleared to participate in sports/activities: YES____ NO____ (Doctor checks one)

Exceptions or limitations (if any):

Doctor's Printed Name & Address: (Stamp is okay)

Doctor's Signature: _____ Date: _____

M.D.? **Yes** ☐ **No** ☐ Doctor's I.D. #: _____