**Victor Valley UHSD Athletics** *Athlete Emergency Information*

**The below information is required to participate in California Interscholastic Foundation athletics. On the bottom of the page is a place for a parent or guardian's signature and the student's signature. By signing this form you will attest that you have read and completed all of the enclosed information concerning the student's insurance coverage, parent or guardian permit to treat, athletic and school code, and general eligibility rules. The signatures will also attest that you understand and agree to the statements within the athletics and/or football participant warning. These signatures also attest to the complete factual nature of all answered questions on the medical history. If these signatures are not provided, then the VVUHSD will not recognize these forms to be complete.**

(Please Print Clearly other then Signatures)

Student Name: _____

**Name (Last,First,M)_____Male / Fem Grade _____DOB _____/____/_____**

**Parents/Guardians: (signer)_____(other)_____**

**Home Phone _____Home Phone_____**

**Work Phone _____Work Phone_____**

**Other Cell Phone#'s_____School_____**

**Athlete's Home Address_____City_____State_____Zip_____**

**Sports (circle each) FB VB Ten CC Sw Wrest Bskb Socc Bsb Sftb T&F Cheer Golf**

**PRIVATE (PRIMARY) INSURANCE**

**Co. Name_____ Pre-authorization phone #_____**

**Insurance Company Address_____**

**Insured_____Group#_____Policy#_____**

**My son / daughter is covered by the above insurance policy. Yes / No**

**Medical Facility of Choice: _____**

**Known Allergies (drug,food,insect,etc…)_____**

**Medications (inhaler, insulin etc…)_____**

**Special Medical Problems_____**

(office use only) Packet Expiration Date: _____

## Parent / Guardian Consent to Treatment of Student-Athlete

**I do hereby authorize VVUHSD athletic trainers or school representative on my behalf to consent to any medical treatment deemed necessary, by any licensed physician / surgeon in the event of illness or injury to the above named minor.**

**This consent to treat is intended to cover any illness or injury sustained while participating in any school athletic competition or practice, on or off campus, and while traveling to and from the event.**

**If, in the judgement of any representative of the school, the above named student needs immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given to said student by any physician, athletic trainer, nurse, hospital, or school representative; and I do hereby agree to indemnify and save harmless the school and any school representative from any claim by any person whomsoever on account of such care and treatment of said student. I hereby authorize any hospital, which has provided treatment to the above named student to surrender custody of that student to the athletic trainer or school representative upon completion of treatment.**

_____ _____ _____

**Parent / Guardian Signature** **Student Signature** **Date**

10/14

_____ _____ _____

Student Store Library Athletic Trainer

## PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

The medical history form must be completed **annually** by parent or guardian **and** student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition, which would make it hazardous to participate in an athletic event as well as assist Medical personnel in the event of injury or illness.

Student's Name: _____ Sex _____ Age _____ Student ID _____

School _____ Grade _____ Date of Birth _____

**Explain "Yes" answers in the box below**. Circle questions you don't know the answers to.** ***Any Yes answer to questions 1, 2, 5, 7, 11, or 16 may require further written medical clearance from a specialist specific to the problem in question. This must occur prior to any conditioning, practices, games, or matches.***

| | | Yes | No |
|---|---|---|---|
| 1. | Have you had a medical illness or injury since your last check up or sports physical? | ☐ | ☐ |
| 2. | Have you been hospitalized overnight in the past year? | ☐ | ☐ |
| | Have you ever had surgery? | ☐ | ☐ |
| 3. | Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler? | ☐ | ☐ |
| 4. | Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? | ☐ | ☐ |
| | Do you have any allergies that would require an EpiPen? | ☐ | ☐ |
| 5. | Have you ever passed out during or after exercise? | ☐ | ☐ |
| | Have you ever been dizzy during or after exercise? | ☐ | ☐ |
| | Have you ever had chest pain during or after exercise? | ☐ | ☐ |
| | Do you get tired more quickly than your friends do during exercise? | ☐ | ☐ |
| | Have you ever had racing of your heart or skipped heartbeats? | ☐ | ☐ |
| | Have you had high blood pressure or high cholesterol? | ☐ | ☐ |
| | Have you ever been told you have a heart murmur? | ☐ | ☐ |
| | Has any family member or relative died of heart problems or of sudden unexpected death before age 50? | ☐ | ☐ |
| | Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome, or abnormal heart rhythm)? | ☐ | ☐ |
| | Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | ☐ | ☐ |
| | Has a physician ever denied or restricted your participation in sports for any heart Problems? | ☐ | ☐ |
| | Has a physician ever diagnosed you with Rhabdomyolysis or Sickle cell trait? | ☐ | ☐ |
| 6. | Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | ☐ | ☐ |
| 7. | Have you ever had a head injury or concussion? | ☐ | ☐ |
| | Have you ever been knocked out, become unconscious, or lost your memory? | ☐ | ☐ |
| | If yes, How many? _____ When was the last concussion? _____ | | |
| | How severe was each one? (Explain below) | | |
| | Have you ever had a seizure? | ☐ | ☐ |
| | Do you have frequent or severe headaches? | ☐ | ☐ |
| | Have you ever had numbness or tingling in your arms, hands, legs, or feet? | ☐ | ☐ |
| | Have you ever had a stinger, burner, or pinched nerve? | ☐ | ☐ |

| | | Yes | No |
|---|---|---|---|
| 8. | Have you ever become ill from exercising in the heat? | ☐ | ☐ |
| 9. | Have you ever gotten unexpectedly short of breath with exercise? | ☐ | ☐ |
| | Do you cough, wheeze, or have trouble breathing during or after activity? | ☐ | ☐ |
| | Do you have asthma? | ☐ | ☐ |
| | Do you have seasonal allergies that require medical treatment? | ☐ | ☐ |
| 10. | Have you had any problems with your eyes or vision? | ☐ | ☐ |
| 11. | Do you have any missing or non-functioning paired organs? | ☐ | ☐ |
| 12. | Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? | ☐ | ☐ |
| 13. | Have you ever had a sprain, strain, or swelling after injury? | ☐ | ☐ |
| | Have you broken or fractured any bones or dislocated any joints? | ☐ | ☐ |
| | Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? | ☐ | ☐ |

If yes, check appropriate box and explain below.

| | | |
|---|---|---|
| ☐ Head | ☐ Elbow | ☐ Hip |
| ☐ Neck | ☐ Forearm | ☐ Thigh |
| ☐ Back | ☐ Wrist | ☐ Knee |
| ☐ Chest | ☐ Hand | ☐ Shin/Calf |
| ☐ Shoulder | ☐ Finger | ☐ Ankle |
| ☐ Upper Arm | | ☐ Foot |

| | | Yes | No |
|---|---|---|---|
| 14. | Do you want to weigh more or less than you do now? | ☐ | ☐ |
| | Do you lose weight regularly to meet weight requirements for your sport? | ☐ | ☐ |
| 15. | Do you feel stressed out? | ☐ | ☐ |
| 16. | Are you under a doctor's care for a current condition? | ☐ | ☐ |

***Females Only***

| | | |
|---|---|---|
| 17. | When was your first menstrual period? | _____ |
| | When was your most recent menstrual period? | _____ |
| | How much time do you usually have from the start of one period to the start of another? | _____ |
| | How many periods have you had in the last year? | _____ |
| | What was the longest time between periods in the last year? | _____ |

Explain All Yes Answers in the Box Below:

_____

_____

_____

_____

If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the VVUHSD and CIF.**

Student Signature: _____ Parent/Guardian Signature: _____ Date: _____

**THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.**

NOTE: History and Consent Must be Completed Prior to Physical Examination

# Pre-participation Physical Examination

(Please Print except for signatures)

**Student's Name**_____ **Sex:**_____ **Age:**_____**Date of Birth:**_____

**Personal Physician:**_____ **Physicians Phone:**_____**Personal Dentist:**_____

**Height**_____ **Weight:**_____ **Blood Pressure:**_____/_____ **Pulse:**_____

**Vision: (R) 20 /**_____ **(L) 20 /** _____ **Corrected Vision: Yes / No** **Contacts: Yes / No**

| | NORMAL | ABNORMAL | | NORMAL | ABNORMAL |
|---|---|---|---|---|---|
| **Skin** | ☐ | ☐ | **Ears** | ☐ | ☐ |
| **Heart** | ☐ | ☐ | **Nose** | ☐ | ☐ |
| **Lungs** | ☐ | ☐ | **Mouth** | ☐ | ☐ |
| **Chest** | ☐ | ☐ | **Throat** | ☐ | ☐ |
| **Liver** | ☐ | ☐ | **Eyes** | ☐ | ☐ |
| **Spleen** | ☐ | ☐ | **Spine** | ☐ | ☐ |
| **Neurological** | ☐ | ☐ | **Genitalia** | ☐ | ☐ |

**Hernia:** _____

**Description of abnormal findings:** _____

_____

## Orthopedic

| | NORMAL | ABNORMAL | | NORMAL | ABNORMAL |
|---|---|---|---|---|---|
| **Neck** | ☐ | ☐ | **Shoulders** | ☐ | ☐ |
| **Elbows** | ☐ | ☐ | **Wrists** | ☐ | ☐ |
| **Hands** | ☐ | ☐ | **Back** | ☐ | ☐ |
| **Hips** | ☐ | ☐ | **Knees** | ☐ | ☐ |
| **Ankles** | ☐ | ☐ | **Feet** | ☐ | ☐ |

**Description of abnormal findings:** _____

_____

☐ **No Restrictions – May Participate in all activities.**

☐ **Cleared after completing evaluation / rehabilitation for:**_____

☐ **Not Cleared for:** ☐ **Collision** ☐ **Contact**

☐ **Non-Contact:**_____**Strenuous**_____**Moderately Strenuous**_____**Non Strenuous**_____

***I certify that I have on this date examined this student and that, on the basis of the examination and the student's medical history furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities. (Note exceptions above)***

**Stamp or Print Name & Address of Physician:**

**Date of Examination:**_____

**Physician's Signature:**_____

**Physcian Lic. #** _____

***This form must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, or a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners.***