GRANADA HILLS CHARTER HIGH SCHOOL

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 turned into Health Office at least 48 hrs prior to tryouts

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

Grade:_____ 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, AND DATE OF EXAM