

Dinuba High School

Sports Participation Health Form

Student Name					
Student ID #	Male	Female	Birth Date	Grade	Telephone #
Name of Parent or Guardian			Address		

To be answered by parent or guardian

Does your child have or ever:	Yes	No	Date	Explain
Been advised by a doctor not to participate in any sport?				
Had a head injury? A. Concussions B. Fainted				
Had a neck or back injury?				
Had an injury to bone, joint ligament, and tendon muscle?				
Had any plates, pins, or screws, placed anywhere in their body?				
Had heart murmur?				
Had a hernia?				
Had heart related illness?				
Had seizures or convulsions?				
Had or diabetes?				
Had an allergic reaction to medication?				
Had surgery or been hospitalized?				
Been under a doctor's care during the past year?				
On medication now? (Please list type and reason)				
Wear glasses/contacts? (Please explain)				
Wear a dental appliance?				
Had a hearing problem?				
Had a problem with menstruation?				
Had a tetanus toxoid immunization in the last 5 years?				

I have completed the above information to the best of my knowledge.

There is no reason why my child _____ should be denied permission to participate in
Name of Child

Interscholastic athletics. I hereby give my permission to allow him/her to be examined at school if necessary and to participate in the school fitness program.

I further authorized my child to be examined and treated by medical and dental staff at _____ for the purpose of fulfilling this requirement necessary to participate in school fitness and sports programs sponsored by the Dinuba Unified School District. **For 2015-2016 athletes, this may include a Tdap vaccine.**

Parent/Guardian Signature _____ Date ____ / ____ / ____

Dinuba Unified School District

Athletic form for all High School Sports

Student Name					
Student ID #	Male	Female	Birth Date	Grade	Telephone #
Name of Parent or Guardian			Address		

Physical Examination To be completed by physician

Height: _____ ft. _____ in.	Weight: _____ lbs.	Blood Pressure: _____ / _____		
	Normal	Clinical Evaluation	Abnormal	Comments
1)		Skin		
2)		Ears (General)		
3)		Nose, Throat, Neck		
4)		Heart & Lungs		
5)		Abdomen		
6)		Genitals, Hernia		
7)		Spine		
8)		Shoulders		
9)		Extremities		
10)		Knees		
11)		Feet		
12)		Reflexes		
13)		Teeth and oral cavity		

Tdap Vaccine	Lab Use Only	This student may compete in:	
Date ____ / ____ / ____	Urine:		All Sports
	HGB:		Contact Sports
			Non-Contact Sports
Other:			

Medical recommendations regarding condition and /or restrictions:

Date of Examination ____ / ____ / ____	Physician's Signature
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Dental recommendations regarding condition and/or restrictions:

Date of Examination ____ / ____ / ____	Dentist's Signature
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