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

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