Form 2

HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT
ANNUAL PHYSICAL SCREENING FORM

SPORTS: (fall)_____ (winter)_____ (spring)_____

Name _____Grade_____ Male ____Female____ Date of birth ___/___/___

Address _____ City & Zip Code_____ Home Phone_____

Name of Father/Guardian_____ Work phone _____Cell phone _____

Name of Mother/Guardian _____Work phone_____ Cell phone_____

Emergency Contact_____ Phone Number_____Insurance _____

I hereby give my consent for the above named student (son/daughter/ward) to compete in sports and to go with a representative of the school on any trips. In case of injury, you are authorized to have him/her treated.

Signature of parent/guardian _____ Date _____

HEALTH HISTORY: TO BE COMPLETED BY PARENT BEFORE DOCTOR EXAM

Any past or present:	Yes	No
Problems with vision	_____	_____
Eyeglasses	_____	_____
Contacts	_____	_____
Problems with hearing	_____	_____
Hearing aid	_____	_____
Blacking out or fainting	_____	_____
Unconsciousness	_____	_____
Convulsions, seizures	_____	_____
Heart problems	_____	_____
Rheumatic fever	_____	_____
Bleeding disorders	_____	_____
Blood sugar problems	_____	_____
Hypoglycemia	_____	_____
Diabetes	_____	_____
Allergies – type _____		
Bee or insect stings	_____	_____
Hospitalizations	_____	_____

	Yes	No
Surgeries	_____	_____
Dental problems	_____	_____
braces	_____	_____
false teeth	_____	_____
Painful joints	_____	_____
Broken bones	_____	_____
Part, date _____		
Knee or ankle problems	_____	_____
Require support/brace	_____	_____
Need for medication	_____	_____
Name _____		
Menstruation problems	_____	_____
Hernias	_____	_____
Asthma	_____	_____

OTHER HEALTH ASPECTS THE DOCTOR AND SCHOOL SHOULD BE AWARE OF:

_____

_____

PHYSICAL EXAM: DATE _____ HEIGHT _____ WEIGHT _____

PULSE: RESTING _____ AFTER ACTIVITY _____ B.P. _____

EYES	_____	LYMPH GLANDS	_____	POSTURE	_____
EARS	_____	THYROID	_____	MUSCLE TONE	_____
NOSE	_____	HEART	_____	REFLEXES	_____
THROAT	_____	LUNGS	_____	ORTHOPEDIC	_____
TEETH	_____	ABDOMEN	_____	SKIN	_____
BRACES	_____	HERNIA	_____	OTHER	_____

I have examined the above student and do recommend that s/he is physically fit for full participation in sports.

Name of physician _____MD or DO Date_____

Signature _____ Phone number _____

Special doctor recommendations or restrictions _____

_____

****PLEASE STAMP WITH PHYSICIAN'S OFFICE STAMP****

Form 3

HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT
MEDICAL INSURANCE CERTIFICATION

Last Name:	**First Name:**	**MI:**

Birth Date:	**Sports/Activity:**		
	Fall	*Winter*	*Spring*

California Law, Education Code, Section 32220-24 requires that every member of a high school athletic team have accidental bodily injury insurance, providing at least $1500 of scheduled medical/hospital benefits. The parent or guardian must provide proof that their family coverage satisfies the Code in relation to medical coverage. If you **have** the $1500, accidental bodily injury insurance, please fill out **ITEM 1** below. If you **do not have** accidentally bodily injury benefits for your son, daughter, or ward, please fill out **ITEM 2** below.

ITEM 1 -- ***MY MEDICAL COVERAGE POLICY FOR AT LEAST $1500 IS ISSUED BY:***

_____ _____

Insurance Company ***Policy Number***

I certify that the student listed above **has** accidental bodily injury insurance providing at least $1500 of scheduled medical/hospital benefits.

_____ / / _____ / /

Student's Signature ***Date*** ***Parent/Guardian Signature*** ***Date***

PROOF OF INSURANCE IS REQUIRED PLEASE ATTACH A PHOTOCOPY OF INSURANCE CARD HERE

ITEM 2

The athlete does not have accidental bodily injury insurance required. **YOU MUST COMPLETE APPROPRIATE MYERS STEVENS & TOOHEY & CO., INC. APPLICATION**

We have subscribed to Myers-Stevens & Toohey & Co., Inc. for athletic insurance, which meet the limits requested. (Myers-Stevens & Toohey & Co. Inc. will send verification of insurance to each school

_____ / / _____ / /

Student's Signature ***Date*** ***Parent/Guardian Signature*** ***Date***