Medical History - Fill in ALL Information!

Athletes Name:	Date of Birth:	Age:	Sex: ☐ M ☐ F	Grade: ☐ 9 ☐ 10 ☐ 11 ☐ 12

Family History: Has any family member ever had…?

Diabetes ☐ Yes ☐ No

Heart attack or disease ☐ Yes ☐ No

Sickle cell trait or disease ☐ Yes ☐ No

Arthritis of bone disease ☐ Yes ☐ No

Has ANYONE in your family died under the age of 30 or unexpectedly ☐ Yes ☐ No

Athlete's Medical History:

1. Have you ever had an illness that
   a. required hospital stay? ☐ Yes ☐ No
   b. lasted longer than a week? ☐ Yes ☐ No
   c. is related to allergies? (i.e. hay fever, hives, asthma, insect sting) ☐ Yes ☐ No
   d. required an operation? ☐ Yes ☐ No
   e. is chronic (i.e. asthma, diabetes, epilepsy)? ☐ Yes ☐ No

2. Have you ever had an injury that:
   a. required you to go to an emergency room or see a doctor? ☐ Yes ☐ No
   b. required you to stay in the hospital? ☐ Yes ☐ No
   c. required an x-ray? ☐ Yes ☐ No
   d. required an operation? ☐ Yes ☐ No

3. Do you take any medication or pills? ☐ Yes ☐ No

Athlete's Medical History: *(cont'd)*

4. Have you ever:
   a. been dizzy or passed our during exercise? ☐ Yes ☐ No
   b. been unconscious or had a concussion? ☐ Yes ☐ No
5. Do you ever feel stressed out or under a lot of pressure? ☐ Yes ☐ No
6. Do you ever feel sad, hopeless, depressed or anxious? ☐ Yes ☐ No
7. Have you ever had a heart murmur, high blood pressure or heart abnormality? ☐ Yes ☐ No
8. Do you have any allergies to medicine or food? ☐ Yes ☐ No
9. Have you ever had: *(check all that apply)*

- ☐ seasonal allergies
- ☐ cerebral palsy
- ☐ emotional difficulties
- ☐ mononucleosis
- ☐ seizures
- ☐ serious or frequent headaches
- ☐ thyroid disease
- ☐ fracture/broken bone
- ☐ collapsed lung
- ☐ pneumonia
- ☐ enlarges spleen or liver
- ☐ hernia
- ☐ kidney disease
- ☐ loss or absence of an organ
- ☐ menstrual disorders
- ☐ ulcers
- ☐ skin disease (impetigo, ringworm, herpes, scabies)
- ☐ neck injury
- ☐ shoulder injury
- ☐ knee injury
- ☐ ankle injury
- ☐ heat related illness

10. Have you ever tested positive for COVID-19? ☐ Yes ☐ No
    If yes, date of positive test: ___________________________

Please explain ALL "YES" responses from above! (Please indicate "RIGHT" or "LEFT" and "AGE" when it occurred?)

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Physical should be completed after June 1st
Valid for upcoming school year only

Attending: ☐ **Turlock High** ☐ **Pitman High**

Turlock Unified School District—Physician's Exam Form

Athletes Name:	Date of Birth:	Age:	Sex: ☐ M ☐ F	Grade: ☐ 9 ☐ 10 ☐ 11 ☐ 12

Athlete's Home Address:	City:	State: CA	Zip:	Home Phone:

Fall Sports (Check One):	Winter Sports (Check One):	Spring Sports (Check One):
☐ Football ☐ Water Polo	☐ Soccer (Boys) ☐ Soccer (Girls)	☐ Golf (Boys) ☐ Track
☐ Cross Country ☐ Tennis (Girls)	☐ Wrestling ☐ Basketball	☐ Baseball ☐ Softball
☐ Golf (Girls) ☐ Cheer		☐ Dive ☐ Tennis (Boys)
☐ Volleyball (Girls)		☐ Volleyball (Boys) ☐ Swim

Height: ____________in Weight: ____________lbs Blood Pressure: ________/________ Pulse:__________

		Normal		Abnormal Findings	
1.	Eyes (General)				
	Right /				
	Left /				
2.	Ears, Nose, Throat				
3.	Mouth, Teeth				
4.	Neck				
5.	Cardiovascular				
6.	Chest, Lungs				
7.	Abdomen				
9.	Genitalia (Male)				
10.	Musculoskeletal				
	a. Neck				
	b. Spine				
		Right	Left	Right	Left
	c. Shoulders				
	d. Arms, Hands				
	e. Hips				
	f. Thighs				
	g. Knees				
	h. Feet				
11.	Neuromuscular				

Comments & Recommendations: ____
____
____

May this student participate in any competitive sport? ☐ Yes ☐ No
If no, what are the restrictions? ____

Physicians Signature: ______________________ Date: _______________ Phone №: ____________________
(*check one*): ☐ M.D. ☐ D.O. ☐ P.A. ☐ N.P.

Physicians Name (Print or Stamp): ______________________ Physician's State License #: __________________

Note: ALL areas must be completed (except genitalia in female); any blank areas, physical will not be accepted!
Physicals must be completed on this card, including the Medical History card on the reverse side of this page.