Tennyson High School
Athletic Department

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Hayward Unified School District, Physical Form

PART 1 (TO BE COMPLETED AND SIGNED BY A PARENT OR LEGAL GUARDIAN)				
LAST NAME	FIRST NAME			GRADE
BIRTHDATE	FALL SPORT	WINTER SPORT	SPRING SPORT	STUDENT ID NUMBER
HEALTH HISTORY (Must be Completed Prior to the Examination) {Please Complete Page 1 & 2}				

	Yes	No	Has this student had any:		Yes	No	Does this student:
1.	⊖	⊖	Chronic or recurrent illness?	16.	⊖	⊖	Wear eyeglasses or contact lenses?
2.	⊖	⊖	Illness lasting over 1 week?	17.	⊖	⊖	Wear dental bridges, braces or plates?
3.	⊖	⊖	Hospitalizations or Surgery?	18.	⊖	⊖	Take any medication? (List Below):
4.	⊖	⊖	Nervous, psychiatric, or neurological condition?	19.	Yes ⊖	No ⊖	**Is there any history of:** Injuries requiring medical care or treatment?
5.	⊖	⊖	Loss or non functioning organs (eye, kidney, liver, testicle) or glands?	20.	⊖	⊖	Neck or back pain or injury?
6.	⊖	⊖	Allergies (medicines, insect bites, food)?	21.	⊖	⊖	Knee Pain or injury?
7.	⊖	⊖	Problems with heart or blood pressure?	22.	⊖	⊖	Shoulder or elbow pain or injury?
8.	⊖	⊖	Chest pain or severe shortness of breath with exercise?	23.	⊖	⊖	Ankle pain or injury?
9.	⊖	⊖	Dizziness or fainting with exercise?	24.	⊖	⊖	Other joint pain or injury?
10.	⊖	⊖	Fainting, bad headaches or convulsions?	25.	⊖	⊖	Broken bones (Fractures)?
11.	⊖	⊖	Concussion or loss of consciousness?	26.	Yes ⊖	No ⊖	**Further History:** Birth defects (corrected or not)?
12.	⊖	⊖	Heat exhaustion, heatstroke, or other	27.	⊖	⊖	Death of parent or grandparent less than

			problems with heat?				40 years of age due to medical cause or condition?
13.	⊜	⊜	Racing heart, skipped, irregular heartbeats, or heart murmur?	28.	⊜	⊜	Parent or grandparent requiring treatment for heart condition less than 50 years of age?
14.	⊜	⊜	Seizures?	29.	⊜	⊜	Been seen by a physician on an emergency or urgent basis in the last 12 months?
15.	⊜	⊜	Severe or repeated instances of muscle cramps?	30.	⊜	⊜	Other concerns not mentioned?
Date of last known tetanus (lockjaw) shot: _____ **Date of last complete physical examination: _____**							

Explain all "Yes" answers here along with any other fact or circumstance that should be disclosed prior to the examination (use reverse side of form if needed):

PARENT / GUARDIAN'S AUTHORIZATION: I authorize a physician or duly authorized and supervised physician's assistant or nurse practitioner to perform a Sports Physical Evaluation on the student. The information set forth above is complete and accurate and I know of no reason why the student cannot fully and safely participate in the listed sports. I understand that this is solely a screening examination and that the absence of any health conditions or concerns listed below does not mean that the student is free from actual or potential harmful health conditions that may cause the student injury or death while participating in sports. Any question or concern I may have regarding the student's health or safety will be referred to our personal physician or health care provider for review and evaluation.

PRINT NAME OF PARENT OR GUARDIAN:	SIGNATURE OF PARENT OR GUARDIAN:	
ADDRESS:	WORK PHONE	HOME PHONE:
REGULAR PHYSICIANS NAME:	OFFICE PHONE:	DATE:

PART 2 (TO BE COMPLETED BY THE EXAMINING PHYSICIAN / PHYSICIAN'S ASSISTANT / NURSE PRACTITIONER)
{Please Complete Page 3}

	NORMAL	**ABNORMAL (Describe)**	
Eyes/Ears/Nose/Throat			Height:
Skin			Weight:
Heart			Pulse: After Exercise:
Abdomen			BP:
Genital/Hernia (males)			***RECOMMENDATION:*** ⦾ Unlimited Participation ⦾ Limited Participation / Specific Sports, Events or Activities ⦾ Clearance withheld pending farthing testing / evaluation ⦾ No Athletic Participation ***ONE OF THE ABOVE MUST BE CHECKED.***
Musculoskeletal:			
a. Neck/Spine/Shoulders/Back			
b. Arms/Hands/Fingers			
c. Hips/Thighs/Knees/Legs			
d. Feet/Ankles			
Neurologic Screening Exam (NSE)			
Comments:			
PRINT NAME OF PHYSICIAN (M.D., D.O., P.A. OR N.P. only)	PHYSICIAN'S SIGNATURE:		DATE: