C.I.F. ATHLETIC PARTICIPATION HEALTH FORM

SANTA BARBARA UNIFIED SCHOOL DI□TRICT
HEALTH SERVICES
STUDENT INFORMATION to be completed by student-Parent signature REQUIRED

Student's Last Name		Student's First Name			
Address		City		Zip	

History:

1. Have you any of the following conditions? If yes to any, please explain below.							
□ Allergies	□ Asthma	□ Seizures	□ Heart murmur	□ A broken bone	□ Diabetes	□ Surgery	□ hospitalization
Explain							

2. Do you wear corrective lenses during sports?	□ Yes	□ No
3. Is your hearing normal?	□ Yes	□ No
4. Do you take any medications?	□ Yes	□ No

If yes, please provide more information as to the name and dose.	Name		Dose	
5. Please note any other medical information that school personnel may need to know:				

Parents/Guardian Signature Permission for EXAM		DATE	

ORIGINAL MUST BE RETURNED TO SCHOOL PHYSICAL EXAMINATION
(Must be completed by an MD, DO, PA, or NP)

Height		Weight		BP		/	Pulse	

Code: 0 = Negative, X=Positive, NE=No Examination

1. Ears, Nose, Throat		8. Musculoskeletal Evaluation					
2. Eyes-pupil equal reactive		8.1 Flexibility/stability of Joints					
• Symmetry of eye movement		Gait		Hand			
3. Dental-Missing teeth		Kneebend					
• Chipped teeth		8.2 Spine-scoliosis					
• Removable teeth		8.3 Swelling of joints					
• Orthodontia		8.4 Muscular Weakness					
4. Lungs		8.5 Atrophy					
5. Heart		Thigh		Shoulder girdle			
6. Abdomen		Calif		Arm			
7. Hernia		9. Incoordlnation/loss of balance					

Additional findings, comments and/or recommendations:		Exam Date	

"I certify that I have on this·date examined this student and that on the basis of the exam requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities."
IF STUDENT IS NOT MEDICALLY FIT TO PARTICIPATE IN ATHLETICS OR IF THERE ARE EXCEPTIONS TO THE ABOVE STATEMENT, EXAMINING PHYSICIAN SHOULD INDICATE ABOVE.

Signature of examining Physician				Phone	
Printed Name		Date		Agency	