

GATEWAY UNIFIED SCHOOL DISTRICT
Athletic Health Screening Examination Record

Current School: Central Valley High School

Current Grade: 8 9 10 11 12

Student / /
Date of Birth _____
Phone

Age: _____ Sex: _____ Height: ' " Weight: _____ lbs

HEALTH HISTORY (to be completed and signed by parent/guardian)

Has your child ever had or do they now have any of the following?

- | YES | NO | |
|------------------------------|--------------------------|---|
| 1. ☐ | ☐ | Chronic or recurrent illnesses _____ |
| 2. ☐ | ☐ | Illnesses lasting more than a week _____ |
| 3. ☐ | ☐ | Hospitalizations _____ |
| 4. ☐ | ☐ | Surgery, other than tonsillectomy _____ |
| 5. ☐ | ☐ | Problem with blood pressure or heart _____ |
| 6. ☐ | ☐ | Dizziness, fainting, or frequent headaches _____ |
| 7. ☐ | ☐ | Ever been knocked out or had a concussion _____ |
| 8. ☐ | ☐ | Neck/back injury or surgery _____ |
| 9. ☐ | ☐ | Knee injury or surgery _____ |
| 10. ☐ | ☐ | Ankle injury or surgery _____ |
| 11. ☐ | ☐ | Other joint sprains or dislocation _____ |
| 12. ☐ | ☐ | Broken bones (fractures) _____ |
| 13. ☐ | ☐ | Organ missing, other than tonsils _____ |
| 14. ☐ | ☐ | Epilepsy or seizure disorder _____ |
| 15. ☐ | ☐ | Asthma or shortness of breath _____ |
| 16. ☐ | ☐ | Diabetes _____ |
| 17. ☐ | ☐ | Heat exhaustion or heat stroke _____ |
| 18. ☐ | ☐ | Nervous disorder or mental illness _____ |
| 19. ☐ | ☐ | Currently taking any medications _____ |
| 20. ☐ | ☐ | Allergic to any medications (aspirin, penicillin, etc) _____ |
| 21. ☐ | ☐ | Wear eyeglasses or contact lenses _____ |
| 22. ☐ | ☐ | Wear dental appliances _____ |
| 23. ☐ | ☐ | Any reason why student should not participate in sports _____ |
| 24. ☐ | ☐ | Family history of death before age 50 _____ |
| 25. ☐ | ☐ | Do you worry about your weight? _____ |
| 26. ☐ | ☐ | Do you binge eat? _____ |
| 27. ☐ | ☐ | Do you force yourself to vomit after eating? _____ |

Please explain any yes answers

Females: Age of onset of menstrual periods: _____ Last menstrual period: _____

Parent/Guardian Permission and Release

I declare that the above information is correct to the best of my knowledge. I understand this is a screening examination to determine if any obvious medical problems exist to prevent my child from participating in school athletic events. This examination is not a complete medical examination. You should contact your family physician for your medical needs. If any medical problems are identified in this screening examination, further examination and treatment should be obtained through your physician. A copy of this record will be given to your child to take home. Please retain for your records.
Please discuss family medical history with your child.

Parent/Guardian Signature

Student Signature

Date

HEALTH SCREENING EXAMINATION

(to be completed and signed by a physician)

Pulse Rate: _____ Blood Pressure: _____

Eye Exam: Far R 20/ _____ L 20/ _____ Both 20/ _____

	Normal	Abnormal	Comments
Mouth/Pharynx			
Heart			
Lungs			
Abdomen			
Genitalia (males only)			
Spine			
Joints			
Extremities			

Based on this history and physical exam the following abnormalities were found and may need treatment:

Recommendations:

- o There were no history or physical findings on this exam which would prohibit this student from participating in competitive athletics.
- o This student should have the above health problems evaluated or treated PRIOR to participating in competitive athletics.
- o This student has health problems which would PROHIBIT them from participating in competitive athletics.

Physician Signature

Date

Physician Name (Print): _____