

Medical History - Fill in ALL Information!

Date of Physical Exam: _____

Athletes Name:	Date of Birth:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Grade: <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 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:

- Have you ever had an illness that
 - required hospital stay? Yes No
 - lasted longer than a week? Yes No
 - is related to allergies? (i.e. hay fever, hives, asthma, insect sting) Yes No
 - required an operation? Yes No
 - is chronic (i.e. asthma, diabetes, epilepsy)? Yes No
- Have you ever had an injury that:
 - required you to go to an emergency room or see a doctor? Yes No
 - required you to stay in the hospital? Yes No
 - required an x-ray? Yes No
 - required an operation? Yes No
- Do you take any medication or pills? Yes No

Athlete's Medical History: (cont'd)

- Have you ever:
 - been dizzy or passed out during exercise? Yes No
 - been unconscious or had a concussion? Yes No
- Do you ever feel stressed out or under a lot of pressure? Yes No
- Do you ever feel sad, hopeless, depressed or anxious? Yes No
- Have you ever had a heart murmur, high blood pressure or heart abnormality? Yes No
- Do you have any allergies to medicine or food? Yes No
- Have you ever had: (check all that apply)

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

Physical should be completed after June 1st

Valid for upcoming school year only

Attending: Turlock High

Pitman High

Date of Physical Exam: _____

Turlock Unified School District—Physician’s Exam Form

Athletes Name:	Date of Birth:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Grade: <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12
----------------	----------------	------	---	--

Athlete’s Home Address:	City:	State: CA	Zip:	Home Phone:
-------------------------	-------	--------------	------	-------------

Fall Sports (Check One): <input type="checkbox"/> Football <input type="checkbox"/> Water Polo <input type="checkbox"/> Cross Country <input type="checkbox"/> Tennis (Girls) <input type="checkbox"/> Golf (Girls) <input type="checkbox"/> Cheer <input type="checkbox"/> Volleyball (Girls) <input type="checkbox"/> Flag Football (Girls)	Winter Sports (Check One): <input type="checkbox"/> Soccer (Boys) <input type="checkbox"/> Soccer (Girls) <input type="checkbox"/> Wrestling <input type="checkbox"/> Basketball	Spring Sports (Check One): <input type="checkbox"/> Golf (Boys) <input type="checkbox"/> Track <input type="checkbox"/> Baseball <input type="checkbox"/> Softball <input type="checkbox"/> Dive <input type="checkbox"/> Tennis (Boys) <input type="checkbox"/> Volleyball (Boys) <input type="checkbox"/> 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 No: _____
 (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.**