ATHLETE NAME: _____ STUDENT ID #: _ _ _ _ _ _ _

**SECTION A - STUDENT-ATHLETE MEDICAL HISTORY** **DO YOU OR HAVE YOU EXPERIENCED ANY OF THE FOLLOWING CONDITIONS?**
**Indicate with a check next to any medical conditions that exist or have existed in the past.**

____ 1. Concussion or had your "bell rung"?
____ 2. Frequent headaches, dizziness, or fainting spells?
____ 3. Neck injury involving nerves, bones, or spinal cord, including "stingers" or "burners"
____ 4. Back or neck injury or pain that required medical treatment?
____ 5. Fractured bone or stress fracture?
____ 6. Significant musculoskeletal injury (sprains, strains to muscles or major joints)?
____ 7. Anemia?
____ 8. Depression?
____ 9. Diabetes?
____ 10. Epilepsy or seizures?
____ 11. Hernia?
____ 12. Kidney disease, liver disease or hepatitis?
____ 13. Mononucleosis?
____ 14. Recurring anxiety?
____ 15. Skin problems?
____ 16. Stomach ulcers?
____ 17. Unusual bleeding or bruising?
____ 18. Eating disorders, weight gain or loss greater than 10 lbs.?
____ 19. Asthma or wheezing?
____ 20. Pain or pressure in the chest?
____ 21. Shortness of breath?
____ 22. Spitting or coughing up blood?
____ 23. A need to take any kind of medicine?
____ 24. Drugs or medicine to enhance athletic ability or strength?
____ 25. Dependency on medicine, drugs, alcohol, tobacco or other substance?
____ 26. Dental plate or broken/chipped tooth?
____ 27. Are you missing any organs (kidney, eye,etc.)?
____ 28. Injury while participating in sports?
____ 29. Surgery or hospitalization not noted above?
____ 30. Illness or injury not noted above?

**FAMILY HISTORY:**
If "yes", provide approximate date and details, including relation to student-athlete.

____ 31. Heart murmur?
____ 32. Chest pain or heart palpitations w/ or w/o exercise?
____ 33. Fainting or passing out?
____ 34. High blood pressure (hypertension)?
____ 35. Irregular heartbeat?
____ 36. Excessive shortness of breath or fatigue with exercise, such as asthma?
____ 37. Sudden death w/o warning before age 50?
____ 38. Other history of heart problems (hypertrophic cardiomyopathy, dilated cardiomyopathy, long QT syndrome, Marfan's syndrome)?

**FEMALE ATHLETES ONLY:**

____ 39. Any female health related conditions that will affect your participation in athletics?

**OTHER CONDITIONS THAT MAY AFFECT ATHLETIC COMPETITION:**

**ATHLETE AND PARENT/GUARDIAN SIGNATURES:**
We, the athlete and parent/guardian, certify that the below health history information is correct and accurate to the best of our knowledge. We know of no health reasons that disqualify this student-athlete from participating in interscholastic athletics. We acknowledge online registration electronic signatures are valid.

| _____ | _____ | _____ |
|---|---|---|
| **STUDENT SIGNATURE** | **PARENT/GUARDIAN SIGNATURE** | **DATE** |

## SECTION B – PHYSICIAN'S CLEARANCE STATEMENT:

### PHYSICIAN'S INSTRUCTIONS

Our pre-participation medical screening form for Liberty Union High School District student-athletes is designed to set a minimum standard and is not all inclusive of tests, procedures, and examinations you may deem necessary. Please be as thorough as possible.

- **Please review the Student's Medical History. It is designed to save you time in your examination.**
- **Complete the Physician's Physical Exam and sign it.**
- **After completing the physical form, please make copies for your medical records and return the original form to the student-athlete who will submit it to athleticclearance.com.**

If you have any questions regarding the student-athlete, please contact LHS Athletic Director John Heinz (925) 634-3521 ext. 5596 or by e-mail at heinzjm@luhsd.net.

Height _____ Weight _____ **Vision: Unaided** **Contacts Glasses** **R 20/ ____** **L 20/ ____** **B 20/ ____**

**URINALYSIS:** **TEST NOT DONE: ____**
**Glucose** _____
**Protein** _____
**pH** _____
**Blood Ketones** _____
**Leukocytes** _____

**CARDIOVASCULAR ASSESSMENT**

| Nml | Abn | |
|---|---|---|
| ___ | ___ | Blood Pressure Sitting___ /____ |
| ___ | ___ | Auscultation - Supine |
| ___ | ___ | Auscultation - Standing |
| ___ | ___ | Pulse_____ Pulse Rate_____ |
| ___ | ___ | Physical Signs of Marfan's Syndrome [Screening if abnormal] |

**MUSCOSKELETAL**

| Nml | Abn | |
|---|---|---|
| _ | _ | C-spine |
| _ | _ | Shoulders |
| _ | _ | Elbows |
| _ | _ | Wrist |
| _ | _ | Hands |
| _ | _ | Spine |
| _ | _ | Hips |
| _ | _ | Knees |
| _ | _ | Ankles |
| _ | _ | Feet |

**GENERAL ASSESSMENT**

| Nml | Abn | |
|---|---|---|
| _ | _ | Head |
| _ | _ | Concussion History |
| _ | _ | Eyes |
| _ | _ | ENT |
| _ | _ | Mouth/Teeth |
| _ | _ | Lungs |
| _ | _ | Abdomen |
| _ | _ | GU |
| _ | _ | Skin |
| _ | _ | Neurological |

**___CLEARED for Athletic Activities w/ No Restrictions.**

**___CLEARED w/ Restrictions as noted**

**___NOT Cleared at this time.**

PLEASE PRINT OR STAMP

PHYSICIAN NAME: _____
ADDRESS:
PHONE #: _____
STATE MEDICAL LICENSE NO.: _____

***STATEMENT OF MEDICAL CLEARANCE FOR INTERSCHOLASTIC ATHLETIC COMPETITION***

I certify that I have reviewed the above student's medical history and the above medical screening information. I have supervised the screening and certify that the above student athlete is healthy enough to participate in athletic competition as marked above.

PHYSICIAN'S SIGNATURE _____ DATE _____