

Student Name: _____ **School:** _____
Address: _____ **Grade:** _____ **Date of Birth:** _____
Phone Number: _____ **Cell Number:** _____

Parent's or Guardian's Permission and Release: I hereby give my consent for the above-named student to represent his or her school in competitive sports except those indicated on this form by the examining physician. I also give my consent for the student to accompany the school team on any of its local or out-of-town trips. The Central Unified School District Board of Education has no responsibility to provide first aid at any of the games and the parent or guardian understands that the risk of injury is assumed by the student and parent when they sign this form. However, in the even physicians, physical therapists, physicians assistants, nurses, or other persons trained in the rendering of first aid are available, as volunteers or otherwise, and render aid to any student injured during the course of any such activities or travel, then the parents/guardians do hereby release and forever discharge such persons and the Central Unified School District Board of Education from any liability arising out of any first aid or immediate treatment of injuries.

Health History: To be completed by the Parent/Guardian (Answer "Yes" or "No" Only)

	Yes	No		Yes	No
1. Chronic/Recurring illness	☐	☐	21. Physician limiting participation due to heart problems	☐	☐
2. Hospitalization or surgery	☐	☐	22. Problem with blood/anemia	☐	☐
3. Under care of physician	☐	☐	23. Problem with liver, spleen or kidneys	☐	☐
4. Currently taking any medication	☐	☐	24. Mononucleosis within last year	☐	☐
5. Organs missing/removed	☐	☐	(if yes, month/year _____)	☐	☐
6. Easily overheated	☐	☐	25. Hernia	☐	☐
7. Heat stress/exhaustion/stroke	☐	☐	26. Neck/back/spine injury or pain	☐	☐
8. Injuries under care of physician	☐	☐	27. Hand/wrist/arm injury or pain	☐	☐
9. Headaches	☐	☐	28. Knee/hip injury or pain	☐	☐
10. Head injury & loss of consciousness	☐	☐	29. Foot/ankle/leg injury or pain	☐	☐
11. Concussions (how many _____)	☐	☐	30. Sudden death of family member before age 50	☐	☐
12. Dizziness/fainting	☐	☐	31. Cancer	☐	☐
13. Seizures/epilepsy	☐	☐	32. Recent weight loss or gain	☐	☐
14. Diabetes	☐	☐	33. Immunizations current	☐	☐
15. Vision problems	☐	☐	34. Tetanus shot (what year _____)	☐	☐
16. Glasses/contacts	☐	☐	35. Ringworm	☐	☐
17. Asthma/wheezing/inhaler	☐	☐	36. High blood pressure	☐	☐
18. Allergies: pollen, stinging insects, food	☐	☐	37. For females, age at onset of periods	☐	☐
19. Chest pain/dizziness with exercise	☐	☐	38. Period regular or irregular	☐	☐
20. Heart murmur/rhythm problem	☐	☐			

Please describe any "YES" answers above or list anything not mentioned: _____

An athletic physical arranged by the school district is not a complete physical examination. It is a screening to detect obvious impairments that might affect the student's safety in sports participation. This evaluation should not be used as a substitute for regular health maintenance examinations with your personal physician.

Verified by: **PARENT/GUARDIAN SIGNATURE** _____ **DATE** _____

PHYSICAL SCREENING

HT _____ WT _____ BP _____ Eyes _____ Pulse (resting) _____ (after exercise) _____
 General _____ Chest _____ Heart _____ Abdomen _____
 GU/Hernia _____ Neck/Back _____ Extremities _____
 Limitations: Yes _____ No _____ (If "yes" list limitations in the Comments area below)
 Comments: _____
 I verify that _____ has been examined by me on _____
 (Student's Name) (Date)

To the best of my knowledge, the above named student is physically able to participate in interscholastic athletics.

Physician/Practitioner Name (please print or type) _____

Physician/Practitioner Signature _____