



**DELTA CHARTER
HIGH SCHOOL**

31400 S. Koster Road, Tracy, CA
95304, United States.
www.dchs.njcsd.net
+1 (209) 830 - 6363

2025 - 2026 Delta Charter Schools Physical Examination and Clearance Form

Check your sports:

FALL

- Cross Country
- Girls Volleyball
- Cheer
- Flag Football

WINTER

- Basketball
- Soccer

- Cheer

SPRING

- Baseball
- Boys Volleyball
- Cheer
- Golf
- Softball
- Track and Field

Student last name: _____ 25-26 Grade: _____

Student first name: _____ Age: _____ Birthdate: _____

Address: _____

Parent/guardian name: _____

Phone: _____ Parent/guardian email: _____

Has student attended any other high school? Yes No

If so, name of high school: _____

This medical history and examination is only intended to determine ability to participate in sports and is not a substitute for regular examinations by your physician.

Have you ever had any of the following (please circle Y or N):

YES	NO		YES	NO	
Y	N	Head injury	Y	N	Anemia, leukemia or other blood disorder
Y	N	Back or neck problems or curvature of the spine	Y	N	Diabetes
Y	N	Broken bones, dislocations, or amputations	Y	N	Hernia, kidney problem, testicle problem
Y	N	Polio or programs with feet, knees, or other joints	Y	N	Enlarged spleen or liver
Y	N	Eye injury, eye surgery, eye disease	Y	N	Surgery other than tonsils
Y	N	Wear glasses, contacts, hearing aids or dentures	Y	N	Family history of sudden death
Y	N	Headaches other than minor headaches	Y	N	Presently taking medication (list below)
Y	N	Drug addiction, mental illness, nervous disorder	Y	N	Allergic to medicine, foods, bee stings, etc.
Y	N	Epilepsy, fainting, or dizzy spells	Y	N	Do you have any ongoing medical problems
Y	N	Lung trouble, shortness of breath, asthma	Y	N	Do you know any reason why you should not participate in sports _____
Y	N	Heart trouble, rheumatic fever			

Current medications: _____



**DELTA CHARTER
HIGH SCHOOL**

31400 S. Koster Road, Tracy, CA
95304, United States.
www.dchs.njesd.net
+1 (209) 830 - 6363

2025 - 2026 Delta Charter Schools Physical Examination and Clearance Form

PHYSICIAN'S PHYSICAL EXAMINATION*

Date: _____ B/P: _____ SEX: M or F Weight: _____ Height: _____

I have examined this student and have found her/him (check one): Fit for Sports In need of further evaluation

Reason for further evaluation: _____

Physician Signature: _____

Physician Stamp Here

Office Phone: _____ Date: _____

** Physical good for one calendar year from date of examination.*

MEDICAL INSURANCE

California law (Education Code Sections 3220-21) requires every member of any interscholastic athletic team, as well as those associated directly with any interscholastic team, athletic event, including song and cheerleaders, team mascots, team managers, etc. to possess accidental bodily insurance providing at least \$1500 of scheduled medical and hospital benefits. Please specify on the form below the required insurance coverage that you have provided for your child. You will promptly notify the school in the event insurance coverage no longer applies to your child.

Insurance Company Name

Group or Policy Number

EMERGENCY CONTACT

Name: _____

Phone: _____