

HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT ANNUAL PHYSICAL SCREENING FORM



SPORTS: (fall) _____ (winter) _____ (spring) _____

Name _____ Grade _____ Male _____ Female _____ Date of birth ____/____/____

City & _____ Home _____
Address _____ Zip Code _____ Phone _____Name of _____
Father/Guardian _____ Work phone _____ Cell phone _____Name of _____
Mother/Guardian _____ Work phone _____ Cell phone _____Emergency _____ Phone _____
Contact _____ Number _____ Insurance _____

I hereby give my consent for the above named student (son/daughter/ward) to compete in sports and to go with a representative of the school on any trips. In case of injury, you are authorized to have him/her treated.

Signature of parent/guardian _____ Date _____

HEALTH HISTORY: TO BE COMPLETED BY PARENT BEFORE DOCTOR EXAM

<u>Any past or present:</u>	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Problems with vision	_____	_____	Surgeries	_____	_____
Eyeglasses	_____	_____	Dental problems	_____	_____
Contacts	_____	_____	braces	_____	_____
Problems with hearing	_____	_____	false teeth	_____	_____
Hearing aid	_____	_____	Painful joints	_____	_____
Blacking out or fainting	_____	_____	Broken bones	_____	_____
Unconsciousness	_____	_____	Part, date _____	_____	_____
Convulsions, seizures	_____	_____	Knee or ankle problems	_____	_____
Heart problems	_____	_____	Require support/brace	_____	_____
Rheumatic fever	_____	_____	Need for medication	_____	_____
Bleeding disorders	_____	_____	Name _____	_____	_____
Blood sugar problems	_____	_____	Menstruation problems	_____	_____
Hypoglycemia	_____	_____	Hernias	_____	_____
Diabetes	_____	_____	Asthma	_____	_____
Allergies - type _____	_____	_____	OTHER HEALTH ASPECTS THE DOCTOR	_____	_____
Bee or insect stings	_____	_____	AND SCHOOL SHOULD BE AWARE OF:	_____	_____
Hospitalizations	_____	_____	_____	_____	_____

PHYSICAL EXAM: DATE _____ HEIGHT _____ WEIGHT _____

PULSE: RESTING _____ AFTER ACTIVITY _____ B.P. _____

EYES	_____	LYMPH GLANDS	_____	POSTURE	_____
EARS	_____	THYROID	_____	MUSCLE TONE	_____
NOSE	_____	HEART	_____	REFLEXES	_____
THROAT	_____	LUNGS	_____	ORTHOPEDIC	_____
TEETH	_____	ABDOMEN	_____	SKIN	_____
BRACES	_____	HERNIA	_____	OTHER	_____

I have examined the above student and do recommend that s/he is physically fit for full participation in sports.

Name of physician _____ MD or DO Date _____

Signature _____ Phone number _____

Special doctor recommendations or restrictions _____

****PLEASE STAMP WITH PHYSICIAN'S OFFICE STAMP****