



SUNNYSIDE ATHLETIC PHYSICAL REGISTRATION INFORMATION



Please complete the online registration and the paperwork for your child, sign the form below and return with the **attached PPE form signed and stamped by your physician**. ***Please make sure to turn all physical paperwork in to the athletic trainer.**

***Complete this online form: tinyurl.com/shsphysicals**

Athlete Name _____ **GRADE** _____ **ID #** _____

Fall Sport _____ **Winter Sport** _____ **Spring Sport** _____

I hereby certify that I completed the online registration for Sunnyside Athletics and am the legal guardian of the student-athlete named above. I certify that I have read and understand the terms of all Sunnyside High, FUSD, and CIF policies. I grant permission for my child to **participate in athletics** at Sunnyside High School. I authorize and release my **student's health information** regarding an athletic injury or medical injury to the certified athletic trainer and nurse at Sunnyside High School.

Parent/Guardian Signature _____ **Date** _____

Parent/Guardian Name _____ **Phone #** _____

Required Medical Information

Personal Medical insurance company name _____

Policy Number or ID Number _____

If you do NOT have personal insurance, you may purchase student insurance @

<http://www.studentinsuranceusa.com>

(Return the certificate of insurance proof with this packet if purchasing student insurance.)

Family Physician _____ **Phone** _____

Preferred Hospital _____

Emergency Contact #1 _____ **Relationship** _____

Phone _____

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Phone _____

Please return this packet to your athletic trainer

FUSD prohibits discrimination, harassment (including sexual harassment), intimidation, and bullying based on actual or perceived race, color, ethnicity, national origin, immigration status, ancestry, age (40 and above), religious creed, religion, political belief or affiliation, gender, gender identity, gender expression, genetic information, mental or physical disability, sex, sexual orientation, marital status, pregnancy or parental status, childbirth, breastfeeding/lactation status, medical condition, military and veteran status, or association with a person or a group with one or more of these actual or perceived characteristics or any other basis protected by law or regulation, in its educational program(s) or employment. Not all bases of discrimination will apply to both education services and employment. For questions or complaints, contact, Teresa Plascencia, Equity Compliance Officer, 2309 Tulare Street, Fresno, CA 93721 (559) 457-3736, Constituent.Services@fresnounified.org; and David Chavez, Title IX Coordinator, 2309 Tulare Street, Fresno, CA 93721 (559) 457-3713, TitleIX@fresnounified.org; and Patrick Morrison, District Section 504 Coordinator, 890 S 10th Street, Fresno, CA 93702 (559) 457-3220, 504@fresnounified.org; and Steven Shubin, Title II/ADA Coordinator, 2309 Tulare Street, Fresno, CA 93721 (559) 457-3520, Accomodations@fresnounified.org.

Preparticipation Physical Evaluation

*PARENT SIGNATURE & consent on page 2

Date of Exam: _____

Student's Name: _____ Sex: _____ Age: _____ Date of Birth: _____ Grade: _____

School: _____ Sport(s): _____

Home Address: _____ Home Phone #: _____

Personal Physician's/Provider's Name: _____ Personal Physician's/Provider's Phone #: _____

In case of emergency, contact: Name: _____ Relationship: _____

Emergency Contact's Telephone #s: Home: _____ Work: _____ Cell#1: _____ Cell #2: _____

Medicines and Allergies: Please list all the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking: _____

Do you have any allergies? ☐ Yes ☐ No. If yes, please identify specific allergy or allergies below:

☐ Medicines: _____ ☐ Pollens: _____ ☐ Food: _____ ☐ Stinging insects: _____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

MEDICAL HISTORY QUESTIONS

Yes No

- Has a doctor ever denied or restricted our participation in sports for any reason?
- Do you have any ongoing medical conditions? If so, please identify below: O Anemia O Diabetes O Other:
- Have you ever spent the night in a hospital?
- Have you ever had surgery ?
- Have you ever passed out or nearly passed out DURING or AFTER exercise?
- Have you ever had discomfort, shortness of breath, lightheadedness, pain, tightness, or pressure in our chest during exercise?
- Does your heart ever race or skip beats during exercise?
- Has a doctor ever told you that you have any heart problems?
- Have you ever had an unexplained seizure? Or history of seizure disorder?
- Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before the age of 35 including drowning or unexplained car crash ?
- Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?
- Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator before age 35?
- Have you ever had an injury, like a sprain, muscle tear, ligament tear, tendinitis, fractured bone or dislocated joint?
- Have you ever had a stress fracture?
- Do you regularly use a brace, orthotics, or any other assistive device?
- Do any of your joints become painful, swollen, feel warm, or look red?
- Do you have any history of juvenile arthritis or connective tissue disease?

20. Do you cough, wheeze, or have difficulty breathing during or after exercise?

21. Have you ever used an inhaler or taken asthma medicine?

23. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?

24. Do you have groin pain or a painful bulge or hernia in the groin area?

25. Have you had infectious mononucleosis (mono) within the last month?

26. Do you have any rashes, pressure sores, or other skin problems?

27. Have you ever had a head injury or concussion?

28. Do you have headaches with exercise?

29. Have you ever had numbness, tingling, weakness, or paralysis in your arms or legs after being hit or falling ?

30. Have you ever become ill while exercising in the heat?

31. Do you get frequent muscle cramps when exercising?

32. Do you or someone in our family have sickle cell trait/disease?

34. Have you had any problems or injuries with your eyes or vision?

35. Do you wear protective eyewear, such as goggles or a face shield?

36. Are you trying to or has anyone recommended that you gain or lose weight?

37. Are you on a special diet or do you avoid certain types of food?

38. Have you ever had an eating disorder?

FEMALES ONLY

Yes No

39. Have you ever had a menstrual period?

40. When was your most recent menstrual period?

Please Explain any "yes Answers here:

Preparticipation Physical Examination

The section below is to be completed by a physician or staff after history and consent forms are completed.

WEIGHT: _____ HEIGHT _____ PULSE _____ BP _____
VISION: R- 20/ _____ L 20/ _____ CORRECTED: YES or NO PUPILS: EQUAL or UNEQUAL

EMERGENCY INFORMATION:

Allergies: _____ Other Information: _____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance Marfan stigmata (kyphoscoliosis, high arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, m myopia, MVP, aortic insufficiency)		
Eyes/ Ears/ Nose/ Throat - Pupils equal - Hearing		
Lymph Nodes		
Heart Murmurs (auscultation standing, supine, +1- Valsalva), Location of point of maximal impulse (PMI)		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
MUSCULOSKELETAL		
Neck/ Back		
Shoulder/ Arm/ Elbow/ Forearm		
Wrist/ Hand/ Fingers		
Hip/ Thigh		
Knee/ Leg / Ankle		
Foot/ Toes		
Functional Duck walk, single leg hop		

CLEARANCE

☐ Medically eligible for all sports/activities without restriction
☐ Medically eligible for all sports/activities without restriction with recommendations for further evaluation or treatment of:
☐ Medically eligible for certain sports/activities:
☐ Not medically eligible pending further evaluation:
☐ Not medically eligible for any sports/activities:

Recommendations: _____

I have evaluated the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent contraindications to practice, tryout, and participate in the sport(s) as outlined above.

Name of Physician/ Provider (print and include official stamp) (MD, DO, NP or PA): _____ Date: _____

Address: _____ Phone: _____

Signature of Physician/ Provider: _____

CONSENT TO TREAT

YES NO I give consent to the Athletic Trainer, Team Physician, and/or other qualified Healthcare Professionals (employed with FUSD) to provide care as indicated.

CONSENT FOR PARTICIPATION IN SPORTS

YES NO I give my consent for my child to participate in school-sponsored athletic programs and activities.

Parent/Guardian _____ Signature _____ Date _____