Santa Maria High School

901 S. Broadway Santa Maria, CA 93454
805-925-2567

PHYSICAL FORM

Date of Exam: _____ **HISTORY FORM -PG 1**

Student's Name _____ **Sex: M / F Age:** _____ **Date of Birth:** _____ **Grade:** _____

Address: _____ **City:** _____ **Phone:** _____

Sport (s): _____ Student ID: _____ **Level:** ____**Varsity** ____**JV** ____**Frosh**

Parents, please fill out prior to physical. Explain "Yes" answers below. Circle questions you don't know the answer to.

		Yes	No
1.	Has a doctor ever denied or restricted your participation in sports for any reasons.	___	___
2.	Do you have an ongoing medical condition?	___	___
3.	Are you currently taking any medicines?	___	___
4.	Do you have allergies to medicine, foods etc?	___	___
5.	Have you ever passed out or nearly passed out DURING exercise?	___	___
6.	Have you ever passed out or nearly passed out AFTER exercise?	___	___
7.	Have you ever had discomfort, pain or pressure in your chest during exercise?	___	___
8.	Does your heart race or skip beats during exercise?	___	___
9.	Has a doctor ever told you that you have: ___ High blood pressure ___ A heart murmur ___ High cholesterol ___ A heart infection		
10.	Has a doctor ever ordered a test for your heart?	___	___
11.	Anyone in your family died for no apparent reason?	___	___
12.	Anyone in your family have a heart problem?	___	___
13.	Has any family member or relative died of heart problems or sudden death before age 50?	___	___
14.	Anyone in your family have Marfan syndrome?	___	___
15.	Ever spent the night in a hospital?	___	___
16.	Ever had surgery?	___	___
17.	Ever had an injury like a sprain, muscle or ligament tear or tendonitis that caused you to miss practice/game? If yes, circle affected area below:	___	___
18.	Ever had any broken/fractured bones or dislocated joints? If yes, circle below:	___	___
19.	Ever had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehab, physical therapy, a brace, cast or crutches? If yes, circle below.	___	___
	Head Neck Shoulder Upper arm Elbow Forearm Hand/fingers Chest Back Hip Thigh Knee Calf/shin Ankle Foot/toes		
20.	Ever had a stress fracture?	___	___
21.	Ever been told that you have or had an x-ray for Atlantoaxial (neck) instability?	___	___
22.	Do you regularly use a brace or assistive device?	___	___
23.	Do you have asthma or allergies?	___	___
24.	Do you cough, wheeze or have difficulty breathing during or after exercise?	___	___
25.	Anyone in your family who has asthma?	___	___
26.	Ever used an inhaler or taken asthma med?	___	___
27.	Were you born w/o or missing a kidney, eye, testicle or any other organ?	___	___
28.	Ever had infectious mononucleosis within the last month?	___	___
29.	Ever had rashes, pressure sores or other skin problems?	___	___
30.	Ever had a herpes skin infection?	___	___
31.	Ever had a head injury or concussion?	___	___
32.	Been hit in head & been confused or lost memory?	___	___
33.	Ever had a seizure?	___	___
34.	Do you have headaches with exercise?	___	___
35.	Ever had numbness, tingling or weakness in your arms or legs after being hit or falling?	___	___
36.	Ever been unable to move your arms or legs after being hit or falling?	___	___
37.	When exercising in the heat, do you have severe muscle cramps or become ill?	___	___
38.	Has a doctor ever told you that you or someone in your family has sickle cell trail/disease?	___	___
39.	Have any problems with your eyes or vision?	___	___
40.	Do you wear glasses or contacts?	___	___
41.	Do you wear protective eyewear?	___	___
42.	Are you happy with your weight?	___	___
43.	Are you trying to gain/lose weight?	___	___
44.	Has anyone recommended you change your weight or eating habits?	___	___
45.	Do you limit or carefully control what you eat?	___	___
46.	Do you have any concerns that you would like to discuss with a doctor?	___	___
	FEMALES ONLY		
47.	Have you ever had a menstrual period?	___	___
48.	How old were you when you had your first menstrual period?	___	___
49.	How many periods in the last 12 months?	___	___

Explain "Yes" answers here: _____

_____

_____

PARENT PERMISSION FOR STUDENT TO PARTICIPATE IN ATHLETIC COMPETITION AND FOR THE PHYSICAL TO BE PERFORMED. I Herby give consent for my child to receive a physical exam from a doctor for the purpose of completing in athletics at Santa Maria High School and also state, that to the best of my knowledge, my answers to the above questions are complete and correct. I hereby give my consent for my son/daughter to compete in athletic competition. In case this student is injured, the coaches are authorized to have him/her treated. I also understand and agree to adhere to the SMHS provisions of the Athletic Department Participation Contract.

This form must be returned to the Athletic Dept. prior to any form of practice and or play.

_____ _____ _____

Parent / Guardian Signature **Date** **Athlete's Signature**

PHYSICAL FORM

EXAMINATION FORM - PG 2

Student's Name: _____ Student ID: _____ **Date of Birth:** _____

Height: _____ Weight: _____ Pulse: _____ BP: _____

Medical	Normal	Abnormal	Initials
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

☐ CLEARED TO PLAY SPORTS ☐ **NOT** CLEARED TO PLAY SPORTS Comment: _____

Name of Physician (**Please print / type**): _____ Date: _____

Signature of Physician: _____ Phone: _____

Address: _____

"This is for athletic participation only and is not intended to be a comprehensive medical evaluation. Certain conditions may exist which may not be identified by this screening. Your personal doctor should be contacted for comprehensive evaluation and screening."

Student Athletes need a current physical each school year to participate in athletics, cheer or dance.

Consent for Emergency Treatment in Advance

Please print all information

Athlete's Last Name: _____ First: _____ Middle: _____ Date of Birth: _____

Address: _____ City: _____ Phone: _____

Allergies: _____ Medications: _____

Personal Doctor: _____ Doctor's Phone: _____

Mother's Name: _____ Phone: _____ Cell: _____ Work: _____ Ext. _____

Father's Name: _____ Phone: _____ Cell: _____ Work: _____ Ext. _____

Other Emergency Contact, Name: _____ Phone: _____ Cell: _____

"We, the parents/guardians of the above named athlete, do hereby consent to any and all emergency medical, hospital and surgical care that may be necessary by a physician, without obtaining further consent provided that the hospital is unable to reach us at the phone numbers listed above."

Today's Date: _____ **Parent / Guardian Signature:** _____