

# SANTA MARIA JOINT UNION HIGH SCHOOL DISTRICT

## Preparticipation Physical Evaluation

### Demographic Information

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Grade \_\_\_\_\_  
 Student ID # \_\_\_\_\_ School \_\_\_\_\_ Pioneer Valley / Righetti / Santa Maria \_\_\_\_\_  
 Address \_\_\_\_\_  
 Parent/Guardian Name \_\_\_\_\_ Phone \_\_\_\_\_

### Family Health History

\*Explain "Yes" answers below. Circle questions if you do not know the answer.

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

### Parental Consent for Physical Examination to be Performed

I hereby give consent for my child to receive a physical exam from a physician for the purpose of competing in athletics in the Santa Maria Joint Union High School District and also state, that to the best of my knowledge, my answers to the family health history questions are complete and correct.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PHYSICAL EXAMINATION

**To be Completed by Physician**

Name \_\_\_\_\_ Date of Exam \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_

Medical	Normal	Abnormal Findings	Initials*
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph Nodes			
Heart			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin			
Musculoskeletal	Normal	Abnormal Findings	Initials*
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

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

**Medical Clearance**

- Cleared without restriction
  - Cleared with recommendations: \_\_\_\_\_
  - Not Cleared
    - For all sports
    - Certain sports \_\_\_\_\_
- Reason: \_\_\_\_\_

I certify that I have on this date examined this student and that, on the basis of my examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it inadvisable for this student to compete in supervised athletic activities. (Note exceptions above)

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD, DO, PA, NP (circle one)