

**PLACENTIA-YORBA LINDA UNIFIED SCHOOL DISTRICT  
SPORTS PRE-PARTICIPATION PHYSICAL**

Name \_\_\_\_\_ Age \_\_\_\_\_  Male  Female  
Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ School Year  20\_\_  20\_\_  20\_\_

**Check sport(s) of participation:**

Band  Baseball  Basketball  Cheer  Color Guard  Cross-country  Dance  Diving  Football  Golf  Lacrosse  Song  
 Tennis  Soccer  Softball  Track/Field  Swim  Volleyball  Water Polo  Wrestling  Other \_\_\_\_\_

**Parent - Please answer questions 1 – 21**

**Has the student/athlete ever:**

**YES NO**

1. Been hospitalized overnight? Diagnosis		
2. Had any chronic illness? <input type="checkbox"/> asthma <input type="checkbox"/> diabetes <input type="checkbox"/> frequent headaches <input type="checkbox"/> bleeding disorder <input type="checkbox"/> Other		
3. Recently taken medication including over-the-counter meds or inhalers? Medication:		
4. Had any allergies (medication, bee stings, etc) Allergy:		
5. Become dizzy or passed out during exercise?		
6. Developed chest pain, shortness of breath or wheezing?		
7. Become tired more quickly than peers during exercise?		
8. Been told that he/she has a heart murmur or heart disease?		
9. Skipped heart beats?		
10. Had anyone in the family develop heart disease or die from heart problems under age 40?		
11. Had a significant head injury or concussion?		
12. Passed out or had a seizure?		
13. Had more than one episode of burner/stinger (pain from neck into arm)?		
14. Had heat cramps or heat exhaustion?		
15. Had a broken/fractured, sprained, or dislocated body part? List body part(s) and date(s) of injury.		
16. Is the student/athlete missing an organ or limb? List body part(s) and date(s) of loss.		
17. Does student/athlete use special equipment? <input type="checkbox"/> Pads <input type="checkbox"/> Braces <input type="checkbox"/> Orthotics <input type="checkbox"/> Prostheses <input type="checkbox"/> Other		
18. Does student/athlete have to gain or lose weight to meet the requirements of his/her sport(s)?		
19. Does student/athlete eat a healthy well balanced diet?		
<b>For females:</b>		
20. Are menses (periods): <input type="checkbox"/> regular/monthly <input type="checkbox"/> irregular <input type="checkbox"/> absent		
21. Last tetanus immunization:		

I hereby authorize the use and/or disclosure of my student/athlete's individual health information for the purpose of medical clearance for participation in the district's sports program. I understand that this authorization is voluntary.

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

**PHYSICAL EXAMINATION BY PHYSICIAN**

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ Pulse \_\_\_\_\_ Body Habitus \_\_\_\_\_  
Visual Acuity: Right eye 20/ \_\_\_\_\_ Left eye 20/ \_\_\_\_\_ Both eyes 20/ \_\_\_\_\_

**Legend:** / = within normal limits + = see comments x = omitted

<b>General</b>	/	+	x	<b>General</b>	/	+	x	<b>Orthopedic</b>	/	+	x	<b>Orthopedic</b>	/	+	x
<b>Head</b>				<b>Heart</b>				<b>Cervical Spine/back</b>				<b>Knees</b>			
<b>Eyes</b>				<b>Abdomen</b>				<b>Arms/elbows/wrists/hands</b>				<b>Ankles/feet</b>			
<b>Ears/nose/throat</b>				<b>Genitalia/hernia</b>				<b>Hips</b>				<b>Flexibility</b>			
<b>Neck</b>				<b>Neurological</b>											

**Comments:**

<b>Discussion Items</b>	<b>Check</b>	<b>MEDICAL CLEARANCE (as appropriate for age and development):</b>	<b>Check</b>
Stretching emphasized	<input type="checkbox"/> yes <input type="checkbox"/> no	Full contact collision level	<input type="checkbox"/> yes <input type="checkbox"/> no
Discussed fitness/ideal weight	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>Clearance deferred</b> or no participation at this time because	<input type="checkbox"/> yes <input type="checkbox"/> no
Discussed treatment of injuries	<input type="checkbox"/> yes <input type="checkbox"/> no		
Discussed prevention of sun/heat-related problems	<input type="checkbox"/> yes <input type="checkbox"/> no		
Discussed testicular cancer exams	<input type="checkbox"/> yes <input type="checkbox"/> no		

<b>MD/DO/FNP:</b>	<b>State License Number:</b>	<b>Phone:</b>
<b>Address ( Doctor's Stamp Required):</b>		<b>Date:</b>