Athletic Physical Evaluation
San Juan Unified School District

PHYSICAL EXAMINATION FORM

STUDENTS NAME: ______________________________________
DATE OF EXAM: _____/____/____

This physical examination form must be reviewed and signed by a Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.) licensed by the State of California (does not include doctors of chiropractic, nurse practitioners, physician assistants).

Date of Birth______________________

Height______ Weight ______% Body Fat (Optional) __________Pulse _________BP___/___(___/___,___/___)

Vision R20/ ___ L20/ ___ Corrected: Y or N Pupils: Equal ___ Unequal ___

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulse			
Lungs			
Abdomen			
Genitourinary (males only)*			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Having a third party present is recommended for the genitourinary examination.

Notes:____

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THIS FORM MUST BE COMPLETED IN ITS ENTIRETY IN ORDER FOR THE STUDENT TO PARTICIPATE IN AN ATHLETIC ACTIVITY.

I hereby certify ____**was examined**

by ____ **on** ______________**and is presently fit to engage in all sports**

except ____.

Attachment(s) Yes ☐ **No** ☐

Name of Doctor (print/type) ____**Medical Group Name**________________

Address____**Phone #**____________ **Date**____________

Signature of Doctor ____

OVER

HISTORY FORM

THE INFORMATION BELOW MUST BE COMPLETED BY PARENT/GUARDIAN PRIOR TO DOCTOR'S SIGNATURE

I hereby state that, to the best of my knowledge, my answers to the questions BELOW are complete and correct.

Signature of athlete ______________________Signature of parent/guardian ______________________________Date_________

Explain "Yes" answers below **Yes/ No**

1. Has a doctor ever denied or restricted your participation in sports for any reason? ☐ ☐
2. Do you have an ongoing medical condition (like diabetes or asthma)? ☐ ☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines? ☐ ☐
4. Do you have allergies to medicines, pollens, foods, or insect stings? ☐ ☐
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. Does your heart race or skip beats after exercise? ☐ ☐
10. Has a doctor ever told you that you have? Check all that apply
    - High blood pressure ☐ ☐
    - High cholesterol ☐ ☐
    - A heart murmur ☐ ☐
    - A heart infection ☐ ☐
11. Has a doctor ever ordered a test for your heart? (For example, ECG, echocardiogram) ☐ ☐
12. Has anyone in your family died for no apparent reason? ☐ ☐
13. Has any family member or relative died of heart problems or of sudden death before age 50? ☐ ☐
14. Does anyone in your family have Marfan syndrome? ☐ ☐
15. Have you ever spent the night in a hospital? ☐ ☐
16. Have you ever had surgery? ☐ ☐
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss practice or game? If yes, circle affected area below. ☐ ☐
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle affected area below: ☐ ☐
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: ☐ ☐

Head, Neck, Shoulder, Upper Arm, Elbow, Forearm, Hand/Finger, Chest, Upper Back Lower Back, Hip Thigh, Knee, Calf/Shin, Ankle Foot/Toes

20. Have you ever had a stress fracture? ☐ ☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? ☐ ☐
22. Do you regularly use a brace or assistive device? ☐ ☐

Yes/No

23. Has a doctor ever told you that you have asthma or allergies? ☐ ☐
24. Do you cough, wheeze, or have difficulty breathing during or after exercise? ☐ ☐
25. Is there anyone in your family who has asthma? ☐ ☐
26. Have you ever used an inhaler or taken asthma medicine? ☐ ☐
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? ☐ ☐
28. Have you had infectious mononucleosis (mono) within the last month? ☐ ☐
29. Do you have any rashes, pressure sores, or other skin problems? ☐ ☐
30. Have you had a herpes skin infection? ☐ ☐
31. Have you ever had a head injury or concussion? ☐ ☐
32. Have you been hit in the head and been confused or lost your memory? ☐ ☐
33. Have you ever had a seizure? ☐ ☐
34. Do you have headaches with exercise? ☐ ☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? ☐ ☐
36. Have you 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 told you that you or someone in your family has sickle cell trait or sickle cell disease? ☐ ☐
39. Have you had any problems with your eyes or vision? ☐ ☐
40. Do you wear glasses or contact lenses? ☐ ☐
41. Do you wear protective eyewear, such as goggles or a face shield? ☐ ☐
42. Are you happy with your weight? ☐ ☐
43. Are you trying to gain or 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? ☐ ☐

FEMALE 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 have you had in the last 12 months? ____

Explain "Yes" answers ____
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All questions or concerns regarding insurance should be referred to Risk Management at 971-7756

RETURN THIS FORM TO THE ATHLETIC DIRECTOR AT YOUR CHILD'S SCHOOL SITE

8/2007