

# POWAY UNIFIED SCHOOL DISTRICT

## Athletic Screening History & Physical Exam

<b>Student Name:</b>	Date of Birth:
Address:	City/Zip:
Home Phone:	High School Graduating Class (Year):
Father's Work Phone:	Mother's Work Phone:
Emergency Contact/Phone:	Emergency Contact/Phone:

### EXPLANATION OF SCREENING PHYSICAL

I realize that the medical evaluations performed are only screens in order to evaluate general health, to disclose existing problems, and to determine my son/daughter's dynamic ability to participate in a given sport so that obvious conditions which might be damaged or aggravated by competitive sports can be found, evaluated and treated so as to prevent further injury. This examination does not guarantee against injury.

Parent Initials \_\_\_\_\_

### AWARENESS OF RISK

STUDENT AND PARENT – I am aware that playing/practicing sports can be a dangerous activity involving many risks of injury. I understand that the risks of participation include, but are not limited to, death, serious neck and spinal cord injuries that may result in complete or partial paralysis, brain damage, serious internal injury to virtually any internal organs, bones, joints, muscles, tendons, or any other aspect of the skeletal system, and serious injury or impairment to other aspects of my body, general health and well being. I understand that the risks of participation may result not only in serious injury, but in impairment of my future ability to earn a living, to engage in other business, social and recreational activities, and generally to enjoy a good life. Because of the dangers of participating in sports, I recognize the importance of following coaches' instructions regarding playing techniques, training, equipment and other team rules, etc. both in competition and practice and agree to obey such instructions.

Parent Initials \_\_\_\_\_

### PERMISSION FOR TREATMENT

I hereby grant permission to the team physicians and those professional personnel designated by Poway Unified School District to treat my son/daughter in the event of an injury. In the event of a serious injury, if I am unable to give my consent at the time, this consent is to include any and all emergency procedures deemed necessary by the attending emergency personnel. I also understand that in the event of injury, every reasonable attempt will be made to contact me prior to securing medical treatment beyond basic first-aid.

Parent Initials \_\_\_\_\_

### PROOF OF INSURANCE

In compliance with California Education Code 32221, I certify that there is in effect at this time insurance coverage for medical expenses resulting from bodily injury of at least \$5,000 for my son/daughter, and that this coverage will remain in effect throughout the time that he/she participates in sports. I also give my permission for the above named student to participate in sports, including regularly scheduled trips by supervised school transportation.

Parent Initials \_\_\_\_\_ Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

**I have read the above statements, EXPLANATION OF SCREENING PHYSICAL, AWARENESS OF RISK, and PERMISSION FOR TREATMENT, and understand them fully and agree/consent to their contents.**

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Student Name: \_\_\_\_\_

**Health History** - Please answer the following in the check box provided. Explain "yes" answers in the box below.

1. Have you ever been hospitalized (overnight)?  Yes  No  
Have you ever had surgery?  Yes  No
2. Are you currently taking medication?  Yes  No
3. Do you have any allergies (medicines, pollen, bees)?  Yes  No
4. Have you ever passed out during exercise? (not from heat)  Yes  No  
Have you ever been dizzy during exercise? (not from heat)  Yes  No  
Have you ever had chest pain?  Yes  No  
Do you tire more quickly than your friends during exercise?  Yes  No  
Have you ever had high blood pressure?  Yes  No  
Have you ever been told you had a heart murmur?  Yes  No  
Have you ever had racing of your heart or skipped beats?  Yes  No  
Has anyone in your family died of heart problems or a sudden death before age 40?  Yes  No  
Does anyone in your family have Marfan's Syndrome?  Yes  No
5. Do you have any skin problems (itching, rashes, breaking out)?  Yes  No
6. Have you ever had a head injury?  Yes  No  
Have you ever been knocked out?  Yes  No  
Have you ever had a seizure?  Yes  No  
Have you ever had a burner/stinger? (pain from neck to arm)  Yes  No
7. Have you ever had heat cramps?  Yes  No  
Have you ever been dizzy or passed out in the heat?  Yes  No
8. Do you use special pads or braces?  Yes  No
9. Have you ever injured (broken/fractured, sprained, dislocated):  
 Hand/fingers  Shoulder  Hip  Shin/calf  
 Wrist/forearm  Neck  Thigh  Ankle  
 Elbow  Chest/ribs  Knee  Foot/toes  
 Upper arm  Back  Stress fractures? \_\_\_\_\_
10. Have you ever had:  
 Mononucleosis  Diabetes  Measles  Hernia(s)  
 Hepatitis  Headaches (frequent)  Asthma  Ulcers  
 Eye/ear injuries  Tuberculosis  Sickle cell trait/disease
11. When was your last tetanus shot? \_\_\_\_\_
12. About your weight: Do you think you are...  just right?  too heavy?  too light/thin?  
Do you like to drink dairy (milk) products?  Yes  No

For females:

When was your first period and how old were you? \_\_\_\_\_

When was your last period? \_\_\_\_\_

Are your periods  Regular/monthly?  Irregular/skip months?

**13. Please ask the doctor to address any questions that you may have. [All discussions are kept confidential.]**

Please explain any "yes" answers here:

Circle the sports you are interested in:

- |              |               |            |               |             |            |             |
|--------------|---------------|------------|---------------|-------------|------------|-------------|
| Baseball     | Cross Country | Golf       | Roller Hockey | Swim/Dive   | Volleyball | Other _____ |
| Basketball   | Field Hockey  | Gymnastics | Soccer        | Track/Field | Water Polo |             |
| Cheerleading | Football      | Lacrosse   | Softball      | Tennis      | Wrestling  |             |

## PRE-PARTICIPATION PHYSICAL EVALUATION

(This form is to be completed by the physician. Submit **original** to RBHS Athletics Office.)

Student Name:		Date of Birth:	Age:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
<b>EXAMINATION</b>					
Height:	Weight:	BP: _____ / _____ (sitting, left arm)	Pulse:	Body Fat % (optional):	Vision: R 20/ _____ L 20/ _____ Corrected <input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL	Normal	Abnormal Findings/ Recommendations
Appearance (to include general congenitive/development deformities)		
Eyes/Ears/Nose/Throat (pupils equal, hearing)		
Lymph Nodes		
Heart (murmurs, location of point of maximal impulse)		
Pulses (simultaneous femoral and radial pulses)		
Lungs		
Abdomen		
Genitourinary (males only, to include hernia) - Optional		
Skin (HSV, lesions suggestive of MRSA, tinea corporis)		
Neurologic (including reflexes)		
MUSCULOSKELETAL / ORTHOPEDIC	Normal	Abnormal Findings/Recommendations
Cervical Spine		
Back (thoracic/lumbar)		
Shoulder/arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional (duck-walk, single leg hop, front squat)		
Tanner Staging 1 – 5 - Optional		

Patient Education Provided:

Stretching emphasized

Discussed prevention of sun/heat-related problems

Discussed fitness/ideal weight

Discussed treatment of acute injuries

Discussed testicular cancer exams

Vaccination record review

- CLEARED for all sports WITHOUT restriction.**       Cleared for all sports without restriction with recommendations outlined above in findings/recommendations
- NOT CLEARED:**     Pending further evaluation     For any sports     For certain sport \_\_\_\_\_
- Needs clearance by specialist:     Orthopedist     Cardiologist     Other \_\_\_\_\_
- Explain \_\_\_\_\_

**Physician's Statement:**

**(Student's name)** \_\_\_\_\_ **was examined by me on (date)** \_\_\_\_\_ for a pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete and parents/guardians.

**Physician's Signature:** **X** \_\_\_\_\_ Date \_\_\_\_\_

**Do not sign without student's name filled in**

Physician's Stamp Here

## RESIDENCE & ELIGIBILITY VERIFICATION

\*\*To be completed by individual with whom student resides\*\*

<b>Student Name:</b>	<b>Grade:</b>	<b>Home #:</b>
<b>Address:</b>	<b>DOB:</b>	<b>Parent Cell #:</b>
	<b>Age:</b>	<b>Parent Cell #:</b>

1. I am the one with whom this student-athlete **resides**: (check one box)
  - Parent     Legal Guardian     Relative     Caretaker     Foster Parent     Emancipated Minor
2. Is this the same residence this athlete had last year?     Yes     No – previous address \_\_\_\_\_
3. Student Status:
  - Continuing Student     Incoming 9<sup>th</sup> Grader     New Resident     Administrative Placement     Intra-District Transfer     Inter-District Transfer

4. School attended last year if athlete is **new and came from another high school**:

Name of School	Address	City/State/Zip
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Sports played at previous school and level of play (varsity, JV, freshman)

- a. Did anyone influence this student to come to this school?     Yes (explain) \_\_\_\_\_     No
- b. Has there been contact with anyone from this school within the past 24 months?     Yes (explain) \_\_\_\_\_     No
- c. Did he/she move with the same family members, caregivers or legal guardians?     Yes     No
- d. Did discipline issues require the athlete to leave his/her former school?     Yes     No

5. I verify that this street address is within the High School boundaries and/or I have followed the District transfer procedures.  
**I also understand that falsifying this information may cause immediate ineligibility for two years and team forfeiture.**

\_\_\_\_\_   
 Print Name of Person Checked on Line 1

<b>X</b> _____	Date	<b>X</b> _____	Date
Signature of Person with Whom Student/Athlete Resides		Student/Athlete Signature	

=====

**ATHLETIC HANDBOOK:** I have reviewed and agree to abide by the guidelines/policies in the Athletic Handbook which is posted on the school website. I acknowledge that it is my responsibility to read and understand these rules and discuss them with my parent/guardian/athlete.  
**Parent Initials** \_\_\_\_\_ **Student/Athlete Initials** \_\_\_\_\_

**CIF CONCUSSION INFORMATION:** I agree that the safety of the athletes always come first. I have read the CIF Concussion Information Sheet posted on the school website and am familiar with the signs and symptoms of a concussion. I understand and support the decision that any athlete suspected of suffering a serious head injury may be removed from a game or practice immediately and will not be allowed to return to activity until medically cleared.  
**Parent Initials** \_\_\_\_\_ **Student/Athlete Initials** \_\_\_\_\_

**CIF SUDDEN CARDIAC ARREST INFORMATION:** I have reviewed the SCA Information Sheet posted on the school website and understand the symptoms and warning signs of SDA and the CIF protocol to incorporate SCA prevention strategies into my students' sports program. I understand and support the decision that any athlete displaying signs or symptoms associated with SCA may not return to play until medically cleared.  
**Parent Initials** \_\_\_\_\_ **Student/Athlete Initials** \_\_\_\_\_

**ATHLETIC POLICY AGAINST HAZING:** Poway Unified School District strives to maintain a healthy athletic program in which all students feel safe, welcome and proud of the school and the athletic programs that they represent. I understand that hazing of any kind is not allowed on this campus and in the athletic program. This includes mental, verbal and physical acts. I further understand that it is my duty to report any acts of hazing that I see to a coach or administrator on campus. I agree to uphold this District policy and understand that any violation will result in my immediate suspension from athletics and further disciplinary action as outlined in District policy and procedures.  
**Parent Initials** \_\_\_\_\_ **Student/Athlete Initials** \_\_\_\_\_

**ETHICS IN SPORTS POLICY:** I accept and understand the Policy Statement, Code of Ethics, The Pillars and Principles of Pursuing Victory With Honor, and the Violations, Minimum Penalties, and Appeal Process of the CIF- San Diego Section ETHICS IN SPORTS Policy posted on the cifsd.org website. I agree to abide by this policy while participating and/or spectating at CIFSDS athletic events regardless of contest site or jurisdiction.  
**Parent Initials** \_\_\_\_\_ **Student/Athlete Initials** \_\_\_\_\_

**MEDIA RELEASE:** I understand that my name, picture, and/or grade point average may be released to the media.  
**Parent Initials** \_\_\_\_\_ **Student/Athlete Initials** \_\_\_\_\_

**I have read all of the above statements and understand them fully and agree/consent to their contents.**

<b>X</b> _____	<b>X</b> _____
Parent/Guardian Signature	Student/Athlete Signature



**MEDICAL INFORMATION RELEASE FORM FOR CO-CURRICULAR ACTIVITY**

This form is provided to the coach and will be taken with the team wherever they travel. Please **fill it out completely and be specific.**

The form gives parental consent for any staff/chaperone approved by the school principal to secure emergency services (medical, dental, paramedic, ambulance) for the student at the parent/guardian expense. Efforts will be made to contact the parent/guardian prior to treatment or hospitalization.

An authorization with a physician's signature must be attached if the athlete takes any prescription medication.

Student Name:	Sport(s):	
Parent/Guardian Name:	Graduating Year:	
Address:	City/ZIP	
Home Phone:	Mother Cell:	Mother Work:
	Father Cell:	Father Work:

**IN CASE OF EMERGENCY, A REPRESENTATIVE OF THE PUSD ATHLETIC DEPARTMENT HAS THE AUTHORITY TO SECURE MEDICAL OR SURGICAL TREATMENT AND TRANSPORT AS NECESSARY. EVERY ATTEMPT WILL BE MADE TO CONTACT THE EMERGENCY PERSONS LISTED BELOW.**

Family Doctor:	Dr. Phone #:
Emergency Person to Contact:	Phone #:
Relationship to Student:	
Emergency Person to Contact:	Phone #:
Relationship to Student:	

List all information helpful to a physician in case of emergency including information which school staff and chaperones need to be aware of regarding the student's safety. Updated information shall be provided by the parent/guardian.

MEDICAL PROBLEMS: (diabetes, asthma, seizures)	TREATMENT:
ALLERGIES: (food, bee stings, medication)	TREATMENT:

**SCHOOL RULES ARE IN EFFECT FOR ALL SCHOOL SPONSORED ACTIVITIES**

**MEDICATION:** Prescription and non-prescription medications are permitted only with a written statement from the physician and parent/guardian indicating desire that the District assist the student as set forth by the physician. If prescription or non-prescription medication is necessary, an **AUTHORIZATION FOR MEDICATION ADMINISTRATION** must be attached. I understand that staff/chaperones may assist my student in taking the medicine(s) as directed by my physician. I will provide the medicine(s) in the prescription container(s) labeled with the name of my student, the prescribing physician's name, and the time and dosage of medication prescribed. I agree to hold harmless and indemnify the Poway Unified School District, its officers, employees, agents or chaperones from and against any and all liability, loss, expense or claims for illness, injury or damage any student may incur from medication assistance.

I UNDERSTAND THAT BY SIGNING THIS FORM:

1. I give permission for my son or daughter to participate in Poway Unified School District athletics.
2. I give permission for staff/chaperones to provide first aid care and secure emergency care at my expense if needed.
3. I release the Poway Unified School District, its officers, employees, agents and its chaperones from any and all liability, loss, expense or claim for illness, injury or damages that may arise from participation in the athletics program or any associated activity. Further, I understand that the District does not provide accident/medical insurance for students and that I am expected to provide such insurance coverage.
4. I am aware that injuries may occur to the athlete while participating in interscholastic athletics. I have been advised of this danger.

**Name of Insurance Company**

**Insurance Policy/Group Number**

**X** \_\_\_\_\_  
Parent/Guardian Signature

**Date**

\_\_\_\_\_  
**Printed Name of Parent/Guardian**