

POWAY UNIFIED SCHOOL DISTRICT

Athletic Screening History & Physical Exam

Student Name:	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 _____

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):

<input type="checkbox"/> Hand/fingers	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Hip	<input type="checkbox"/> Shin/calf
<input type="checkbox"/> Wrist/forearm	<input type="checkbox"/> Neck	<input type="checkbox"/> Thigh	<input type="checkbox"/> Ankle
<input type="checkbox"/> Elbow	<input type="checkbox"/> Chest/ribs	<input type="checkbox"/> Knee	<input type="checkbox"/> Foot/toes
<input type="checkbox"/> Upper arm	<input type="checkbox"/> Back	<input type="checkbox"/> Stress fractures?	_____
10. Have you ever had:

<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Measles	<input type="checkbox"/> Hernia(s)
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Headaches (frequent)	<input type="checkbox"/> Asthma	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Eye/ear injuries	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> 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:

14. Circle the sports you will be participating in:

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

Other(s): _____

Physical Examination

(To be completed by Medical Personnel)

Height _____

Blood Pressure _____ (sitting, left arm)

Vision (optional)

Weight _____

Pulse _____

Left eye 20/ _____

Right eye 20/ _____

Body fat _____% (optional)

Both eyes 20/ _____
with / without glasses

1. Skin	
2. Head	
3. Eyes (PERLA, EOMI, Fungi)	
4. Ears, nose, throat	
5. Neck	
6. Lymphatic's	
7. Respiratory	
8. Cardiovascular	
Heart (murmurs?)	
9. Abdomen	
10. Genitalia (include. hernia exam – optional)	
11. Extremities	
12. Neuralgic	
Reflexes	
13. Orthopedic	
Cervical spine/back	
Arms/elbows/wrist/hands	
Hips	
Knees	
Ankles/feet	
14. Developmental	
Tanner staging 1 – 5 (optional)	

√ = within normal limits
+ = see comments
X = omitted

Comments/Recommendations:

MEDICAL CLEARANCE

(As appropriate for age and development)

Full contact/collision level (full, unrestricted participation)

Limited contact/impact

Non contact: strenuous

Non contact: non-strenuous

Clearance deferred or no participation at this time because:

Needs clearance by specialist

Orthopedist Cardiologist

Other: _____

Needs to complete rehabilitation for current condition(s) prior to participation

Patient Education provided:

Stretching emphasized

Discussed prevention of sun/heat-related problems

Discussed fitness/ideal weight exams

Discussed treatment of acute injuries

Discussed testicular cancer

Physician's Statement:

(Student's name) _____ was examined by me on _____ (date) and found physically fit to engage in high school athletics. Results are to encourage, but in no way guarantee, the fitness and safety of this athlete.

Practitioner Signature: _____

Date _____

M.D. / D.O. / N.P. / P.A.

Do not sign without student's name filled in



Physician's Office Stamp HERE
(REQUIRED)

BRONCO ATHLETICS

ATHLETIC PARTICIPATION SIGNATURE FORM

STUDENT NAME: _____ (Please Print)

GRADE: _____ SPORT(s): _____

RANCHO BERNARDO HIGH SCHOOL ATHLETIC HANDBOOK

I have reviewed and agree to abide by the athletic guidelines/policies in the Rancho Bernardo Student Handbook available on the Rancho Bernardo High School Website, www.rbhs.com. By signing below, I acknowledge that it is my responsibility to read and understand these rules and discuss them with my parent/guardians.

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 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. By signing below, 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.

ETHICS IN SPORTS POLICY

By signing below, 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, (www.cifsd.org/ethics-forms.asp). I agree to abide by this policy while participating and/or spectating at CIF athletic events regardless of contest site or jurisdiction.

RELEASE AUTHORIZATION

I understand that my name, picture, and/or grade point average (if 3.0 or above) may be released to the media.

Student's Name (Printed)

Parent/Guardian Name (Printed)

Student's Signature

Parent/Guardian Signature

Date

Date

This "COACHES MEDICAL INFORMATION CARD" is provided to the coach. It will be taken with the team whenever the team travels to an away contest. Please fill out completely and be specific. An authorization with a physician's signature must be attached if the athlete takes any prescription medication.

- CONFIDENTIAL -

MEDICAL INFORMATION RELEASE FORM FOR CO-CURRICULAR ACTIVITY RANCHO BERNARDO HIGH SCHOOL

This form MUST be completed and signed by the student's parent/guardian. 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 parent/guardian expense. Efforts will be made to contact the parent/guardian prior to treatment or hospitalization.

PLEASE PRINT AND FILL OUT COMPLETELY, SIGN AND RETURN

Student's Name:	Sport(s):
Parent/Guardian Name:	High School Graduating Class (Year):
Address:	City, Zip
Home Phone:	Cell/Work Phone:

IN CASE OF EMERGENCY, A REPRESENTATIVE OF THE ATHLETIC DEPARTMENT HAS THE AUTHORITY TO SECURE MEDICAL OR SURGICAL TREATMENT AND TRANSPORT AS NECESSARY. WE WILL ATTEMPT TO CONTACT THE EMERGENCY CONTACTS LISTED BELOW IF UNABLE TO CONTACT PARENT/GUARDIAN.

Family Doctor	Phone
Emergency Person to Contact:	Phone
Relationship to Student/Athlete:	
Emergency Person to Contact:	Phone
Relationship to Student/Athlete:	

RANCHO BERNARDO HIGH SCHOOL TRIP PERMISSION

SCHOOL RULES ARE IN EFFECT FOR ALL SCHOOL-SPONSORED ACTIVITIES

I UNDERSTAND THAT BY SIGNING THIS FORM:

1. I give my permission for my son/daughter to participate in RBHS athletics.
2. I give my 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 or Rancho Bernardo High School 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.

Signature of Parent/Guardian

Date

Name of Insurance Company

Policy #

HEALTH INFORMATION

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

	USUAL SYMPTOMS	CARE OR MEDICATION NEEDED	METHOD OF ADMINISTRATION
MEDICAL PROBLEMS (i.e. diabetes, asthma, seizures)			
ALLERGIES (i.e. food, bee stings, medication)			

CURRENTLY UNDER MEDICAL CARE? (Explain)

OTHER FACTORS THAT MAY AFFECT THE CARE OF YOUR STUDENT/ATHLETE. BE SPECIFIC.

ADDITIONAL RECOMMENDATIONS:

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 Rancho Bernardo High School and its chaperones from and against any and all liability, loss, expense or claims for illness, injury or damage any student may incur from medication assistance.

Signature of Parent/Guardian

Date

Printed Name of Parent/Guardian

Date