

POWAY UNIFIED SCHOOL DISTRICT
Athletic Screening History & Physical Exam

Please indicate:

Mt. Carmel HS

Poway HS

Rancho Bernardo HS

Westview HS

Student Name:	Student ID #:
Address:	Date of Birth:
City/Zip:	Graduating Year:
Home Phone:	Parent Name/Work Ph:
Emergency Contact/Phone:	Parent Name/Work Ph:

EXPLANATION OF SCREENING PHYSICAL

I realize that the medial 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.

Parents 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 participant 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 participant 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.

Parents 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 that 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 medial treatment beyond basic first-aid.

Parents Initials _____

PROOF OF INSURANCE

In compliance with California Education Code 32221, I certify that there s in effect at this time insurance coverage for medial 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 supervision school transportation.

Parents Initials _____ Insurance Carrier _____ Policy # _____

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

Parent Signature _____ Date: _____

Student Signature _____ Date: _____

The following questions are to be answered by either a yes or no. Please check appropriate space and explain ALL "yes" answers.

- | | YES | NO |
|--|-----|-----|
| a. Have you been under a doctor's care in the past 12 months? | () | () |
| b. Have you been in the hospital in the past 12 months? | () | () |
| c. Have you had any type of surgery? | () | () |
| d. Do you want to talk to a doctor about a health problem or injury? | () | () |
| e. Has anyone in your immediate family ever had: | | |
| Diabetes? | () | () |
| Heart trouble? | () | () |
| High blood pressure? | () | () |
| f. Has anyone in your family, under the age of 50 died suddenly? | () | () |

Example all previous "yes" answers _____

- | | | |
|---|-----|-----|
| g. Have you had or do you now have: | | |
| Brain concussion (head injury)? | | |
| Tendency to faint? | () | () |
| Skull fracture? | () | () |
| Convulsions or epilepsy? | () | () |
| Neck injury? | () | () |
| h. Have you had or do you now have: | | |
| Impaired vision in one eye? | () | () |
| To wear glasses or contact lenses? | () | () |
| Temporary loss of vision? | () | () |
| i. Have you had or do you now have: | | |
| Heat illness? | () | () |
| Stinger, burner, or pinched nerve? | () | () |
| j. Have you had or do you now have: | | |
| Hearing loss? | () | () |
| Perforated eardrum? | () | () |
| Discharge from ear(s) (recurrent infections)? | () | () |
| Sinus infections? | () | () |
| Broken nose? | () | () |
| Dental plate (dentures)? | () | () |
| Orthodontia (teeth straightened)? | () | () |
| k. Have you had or do you now have: | | |
| Hernia? | () | () |
| Kidney problems? | () | () |
| Loss of function or absence of testicles (s) [men]? | () | () |

Explain all previous "yes" answers _____

- | | | |
|-------------------------------------|-----|-----|
| l. Have you had or do you have: | | |
| Diabetes? | () | () |
| Tendency to bleed or bruise easily? | () | () |
| Anemia? | () | () |
| m. Have you had or do you now have: | | |
| Asthma? | () | () |
| Exercised induced asthma? | () | () |
| Allergies? | () | () |
| Bee-sting reaction? | () | () |
| Do you need an Epi pen? | () | () |
| Reaction to medication? | () | () |
| Which medicine? _____ | | |
| _____ | | |
| _____ | | |

Explain all previous "yes" answers. _____

- | | | |
|---|-----|-----|
| n. Have you had or do you now have: | | |
| Weight problems under/overweight)? | () | () |
| Eating problems? | () | () |
| Dieting problems? | () | () |
| o. Do you: | | |
| Smoke? | () | () |
| Take any medicine regularly? | () | () |
| If YES, name of medicine _____ | | |
| Take any medicine for emergency uses | () | () |
| If YES, name of medicine _____ | | |
| p. Have you had or do you now have: | | |
| High blood pressure? | () | () |
| Heart trouble or murmur? | () | () |
| Persistent cough? | () | () |
| Dizziness or faintness with exercise? | () | () |
| Chest pain / discomfort with exercise? | () | () |
| q. Do you wish to discuss an emotional problem with the doctor? | () | () |
| r. Have you have a loss of a paired organ? | () | () |
| Which one? _____ | | |
| s. Have you ever been told to give up sports because of a health problem? | () | () |
| t. Are there any questions you have for the doctor? _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |

Explain all previous "yes" answers _____

The following questions are to be answered by either a **yes** or **no**. Please check appropriate space and explain ALL "yes" answers.

	YES	NO	Women only.	YES	NO
u. Do you use any orthopedic braces?	()	()	v. Age at the onset of menstruation? _____	()	()
Explain _____			Do you have menstrual problems?	()	()
			Have you ever missed 3 or more periods in a row?	()	()

FOR THE FOLLOWING QUESTIONS BE AS SPECIFIC AS POSSIBLE. DETAIL WHAT HAPPENED, *WHEN*, RIGHT OR LEFT, CASTED OR IMMOBILIZED, HOW LONG AND REHABILITATION, DOCTOR'S NAME AND CITY.

Yes No 1. Have you had a wrist/hand fracture of injury? _____

Yes No 2. Have you had a severe sprain, dislocation, or fracture to either elbow? _____

Yes No 3. Have you had a shoulder dislocation, separation, or other injury? _____

Yes No 4. Have you had knee arthroscopy or surgery? What other injuries have you had to your knees?

Yes No 5. Have you experienced a sever ankle sprain or injury to your foot or ankle? _____

Yes No 6. Have you had an injury to your hip or pelvis area? _____

Yes No 7. Have you had an injury to your upper or lower back? _____

Yes No 8. Do you experience pain in your back? Seldom____ Occasionally ____ Frequently____

Yes No 9. Do you wear orthodics? Why? Who prescribed them? _____

Yes No 10. Have you had any problems with muscle strains or pulls? _____

Yes No 11. Have you had any other significant injuries? _____

Yes No 12. Have you had any other operations in the past four years? Explain in detail: _____

Yes No 13. Are you currently on prescribed medication? Indicate drug, doctor, and why it was prescribed and dosage: _____

Yes No 14. Are you currently under the care of a physician? Give length of time and reason for care: ____

Student Name: _____ Athletic Screening History & Physical Exam

Circle the sport you will be participating in:

Baseball
Basketball
Cheerleading
Cross Country
Field Hockey

Football
Golf
Gymnastics
Lacrosse
Other(s)

Soccer
Softball
Swimming
Track/Field

Tennis
Volleyball
Water Polo
Wrestling

Physical Examination

(To be completed by Medical Personnel)

Height _____ Blood Pressure _____ (sitting, left arm) Vision (optional)
 Left eye 20/ _____
 Weight _____ Pulse _____ Right eye 20/ _____
 Both eyes 20/ _____
 with / without glasses

Body fat _____ % (Optional)

1. Skin	
2. Head	
3. Eyes (PERLA, EOMI, Fundi)	
4. Ears, nose, throat	
5. Neck	
6. Lymphatic	
7. Respiratory	
8. Cardiovascular	
Heart (murmurs?)	
9. Abdomen	
10. Genitalia (include hernia exam - optional)	
11. Extremities	
12. Neurologic	
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)

Please indicate:

Full, unrestricted participation

OR

Clearance deferred or no participation at this time because:

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

Notes: _____

Needs clearance by specialist:

Orthopedist

Cardiologist

Other:

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./D.C.

Physician's Office Stamp HERE



This is provided to the coach. It will be taken with the team whenever the team travels to away contests. Please fill out completely and be specific. An authorizing with a physician's signature must be attached if the athlete takes any prescription medication.

~ CONFIDENTIAL ~

**MEDICAL INFORMATION RELEASE FORM FOR CO-CURRICULAR ACTIVITY
WESTVIEW 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 (medial, dental, paramedic, ambulance) for the student at parent/guardian expense. Efforts will be made to contact the parent/guardian prior to treatment or hospitalization.

Student's Name	Sport(s)
Parent/Guardian Name	GRADUATING CLASS (year)
Address:	City/ZIP
Home Phone:	Work/Daytime Phone

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

Family Doctor _____	Phone# _____
Emergency Person to Contact _____	Phone# _____
Relationship to student _____	
Emergency Person to Contact _____	Phone# _____
Relationship to student _____	

**WESTVIEW 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 Westview High School 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 Westview 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/medial 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 SYMPTIONS	CARE OF 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. 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 students, 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 Westview 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

Parent/Guardian Phone