



Attention Parents/Guardians and Athletes:

All Athletic Physicals are valid for 12 Months from the date they occurred.

- Each school year all prospective athletes must complete and return a Ticket to Play/ Athletic Packet before trying out for any sport. **Please, *do not turn in front-to-back.***
- If your physical will expire in the middle of the season, you must have a new physical done before tryouts.
Ex: If your physical was done in July 2020, you will need a new physical for the 2021-22 school year which will be good for the entire year. If you had your physical in January 2021, your physical is good only for the Fall 2021-22 sport season.
- Completed packets must be turned in by the pre-designated date below in order to ensure an athlete's Ticket to Play will be ready on the 1st day of tryouts for a sport. Late paperwork is subject to a minimum 3-4 day turn-around before a Ticket to Play can be issued.

Winter Sports 10/22/21

Spring Sports 1/21/22

- If you are a new student (new to RBHS/PUSD), you can get your physical from your old school and turn it in (as long as it's not expired or will expire during the sport season) you still must fill out and return the RBHS Ticket to Play paperwork.

If you have other questions, please ask!

Athletic Assistant: Teresa Small tsmall@powayusd.com or (858) 485-4800 ext. 4508

Athletic Trainer: Robbie Bowers, ATC rbowers@powayusd.com

The Poway Unified School District (PUSD) is an equal opportunity employer/program and is committed to an active Nondiscrimination Program. PUSD prohibits discrimination, harassment, intimidation, and bullying on the basis of actual or perceived race, color, ancestry, national origin, nationality, immigration status, ethnicity, ethnic group identification, age, religion, marital or parental status, physical or mental disability, sex, sexual orientation, gender, gender identity, or gender expression or association with a person or group with one or more of these actual or perceived characteristics. For more information, please contact the Title IX/Equity Compliance Officer,

Associate Superintendent of Personnel Supportive Services,

Poway Unified School District, 15250 Avenue of Science, San Diego, CA 92128-3406, 858-521-2800, extension 2761

Parent/Athlete Copy
DO NOT TURN IN THIS PAGE

POWAY UNIFIED SCHOOL DISTRICT
Athletic Screening History & Physical Exam



Student Name (<i>Print Clearly</i>): First: _____ Last: _____	Date of Birth: _____
Address: _____	Graduating Year: <input type="text"/>
	Home Phone: _____
Parent/Guardian Cell Phone: _____	Parent/Guardian Cell 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/Guardian Signature **X** _____ Date _____

Student Signature **X** _____ Date _____

Student Name (Print Clearly):

First: _____ Last: _____

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 (<i>Print Clearly</i>): First: _____ Last: _____		Date of Birth: _____	Current Age: _____
EXAMINATION			
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 (*Print Clearly*) _____ **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



POWAY UNIFIED SCHOOL DISTRICT 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 (<i>Print Clearly</i>) First: _____ Last: _____		Sport(s)- Check all that apply <input type="checkbox"/> Fall <input type="checkbox"/> Winter <input type="checkbox"/> Spring State Sport(s) Name: _____
Parent/Guardian Name: _____		Graduating Year: <input type="text"/> Fall Grade (circle one): 9 10 11 12
Address: _____ City: _____ Zip: _____		
Home Phone: _____		
Parent/Guardian Cell: _____		Parent/Guardian Cell: _____

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 #: _____
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Emergency Contact 1 Name: First: _____ Last: _____	Emergency Contact 2 Name: First: _____ Last: _____
Relationship to Student: _____	Relationship to Student: _____
Phone #: _____	Phone #: _____

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

