



POWAY UNIFIED SCHOOL DISTRICT

Athletic Screening History & Physical Exam

Complete using **BLUE** or **BLACK** ink.

Student Name:	Student ID #:
Address:	Date of Birth:
City/Zip:	High School Graduating Class of (Year):
Parent/Guardian {1} Name/Cell Phone:	Parent/Guardian {2} Name/Cell Phone:
Sport(s)	

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/Guardian are responsible for reporting serious illnesses/injuries sustained after the physical examination date.

Parent/Guardian Initials _____

AWARENESS OF RISK

STUDENT AND PARENT/GUARDIAN – 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/Guardian 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/Guardian 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/Guardian Initials _____ Insurance Carrier _____ Policy # _____
{If SSN, provide only last 4-digits}

I have read the above statements, EXPLANATION OF SCREENING PHYSICAL, AWARENESS OF RISK, PERMISSION FOR TREATMENT, and PROOF OF INSURANCE and understand them fully and agree/consent to their contents.	
Parent/Guardian Signature _____	Date _____
Student Signature _____	Date _____



RESIDENCE & ELIGIBILITY VERIFICATION

Complete using **BLUE** or **BLACK** ink.

To be completed by individual with whom student resides and student

Student Name:	Student ID #:
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- I am the with whom this student-athlete **resides:** (check one box)
 Parent Legal Guardian Relative Caretaker Foster Parent Emancipated Minor
- Is this the same residence this athlete had last year? Yes No – Previous Address _____
- Student Status:
 Continuing Student Incoming 9th Grader New Resident Administrative Placement Intra-District Transfer Inter-District Transfer

4. School attended last year:

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

- NEW and/or INCOMING to Westview, and/or a TRANSFER from a high school other than Westview? Complete items a through d:**
 - Did anyone influence this student to come to this school? Yes (explain) _____ No
 - Has there been contact with anyone from this school within the past 24 months? Yes (explain) _____ No
 - Did he/she move with the same family members, caregivers or legal guardians? Yes No
 - Did discipline issues require the athlete to leave his/her former school? Yes No

6. I verify that the residence street address is within the High School boundaries and/or I have followed the District transfer procedures.

Address:	Parent/Guardian Cell #:	Student Grade:
City/State Zip:	Student DOB:	Student Age

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

X _____ **Signature of Person with Whom Student/Athlete Resides** _____ **Date**

X _____ **Student/Athlete Signature** _____ **Date**

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/Guardian 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/Guardian Initials _____ **Student/Athlete Initials** _____

CIF SUDDEN CARDIAC ARREST {SCA} INFORMATION: I have reviewed the SCA Information Sheet posted on the school website and understand the symptoms and warning signs of SCA 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/Guardian 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/Guardian 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 school and 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/Guardian Initials _____ **Student/Athlete Initials** _____

MEDIA RELEASE: I understand that my name, picture, and/or grade point average may be released to the media.

Parent/Guardian Initials _____ **Student/Athlete Initials** _____

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

X _____ **Parent/Guardian Signature** _____ **Date**

X _____ **Student/Athlete Signature** _____ **Date**



Complete using **BLUE** or **BLACK** ink.

Student Name: _____

Student ID #: _____

Health History - Check the appropriate box provided. **Explain all "yes" answers in the box below.**

1. Have you ever been hospitalized (overnight)? Yes No
 - a. Have you ever had surgery? Yes No
2. Are you currently taking medication? List medications below. Yes No
3. Do you have any allergies (medicines, pollen, bees)? Yes No
 - a. Do you need to carry an EpiPen? Yes No
4. Have you ever passed out during exercise? (not from heat) Yes No
 - a. Have you ever been dizzy during exercise? (not from heat) Yes No
 - b. Have you ever had chest pain? Yes No
 - c. Has a doctor ever ordered a test for your heart? {ECG/EKG, Echocardiogram} Yes No
 - d. Lightheaded/more short of breath than expected during exercise? Yes No
 - e. Have you ever had high blood pressure? Yes No
 - f. Have you ever been told you have a heart murmur? Yes No
 - g. Have you ever had racing of your heart or skipped beats? Yes No
 - h. Does anyone in your family have Marfan's Syndrome {heart}? Yes No
 - i. Has anyone in your family died of heart problems or a sudden-death before age 40? 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
 - a. Have you ever experienced loss of consciousness? Yes No
 - b. Have you ever had a seizure? Yes No
 - c. Have you ever had a burner/stinger? (pain from neck to arm) Yes No
7. Have you ever had heat/muscle cramps? Yes No
 - a. Have you ever been dizzy or passed out in the heat? Yes No
8. Do you regularly use a brace{s}, orthotics, or other assistive device? Yes No
9. Have you ever injured (broken/fractured, sprained, dislocated): **{Checked answers require explanation in the box below; provide month/year.}**

<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: **{Checked answers require explanation in the box below; provide month/year.}**

<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Measles	<input type="checkbox"/> Hernia(s)	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Dental Issues
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Headaches	<input type="checkbox"/> Asthma	<input type="checkbox"/> Use Inhaler	<input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> Eye injuries	<input type="checkbox"/> Wear corrective lenses/glasses for vision	<input type="checkbox"/> Sickle cell trait/disease			
<input type="checkbox"/> Ear injuries/Hearing loss	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Kidney/Bladder	<input type="checkbox"/> Missing organ/s		
11. About your weight: Do you think you are... just right? too heavy? too light/thin?
12. Are you on a special diet or do you avoid certain foods? Yes No
13. Have you had, or do you currently have: ADD/ADHD Anxiety Depression IEP 504
14. *Females:*
 At what age was your first period? _____ Month/Day of last period? _____
 Are your periods Regular/monthly Irregular/skip months?

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

Explain all "yes" &/or checked answers above; provide month/year.{Use back of form if necessary.}**Sign below.**

Student Signature _____ Date: _____

Parent/Guardian Signature _____ Date: _____

Student Name:	Student PUSD ID #:
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COVID-19 PRE-SCREENING QUESTIONNAIRE

We appreciate your cooperation and patience in helping to keep our students and staff safe and healthy.

IN THE LAST TWO WEEKS: Have you experienced any:

Fever (100.4°+)? YES NO

Coughing? YES NO

Sore Throat? YES NO

Shortness of Breath or Difficulty Breathing? YES NO

Persistent Muscle Aches? YES NO

New Confusion or Unable to Awake? YES NO

Chills or Repeated Shaking Chills? YES NO

Loss of Taste or Smell? YES NO

Bluish Lips or Face? YES NO

Purple Skin Lesions on Feet? YES NO

Chest Pain, Pressure, or Tightness? YES NO

Fatigue or Difficulty with Exercise? YES NO

Nausea, Vomiting, or Diarrhea? YES NO

1. Have you been in personal contact with a person infected with current or past Coronavirus?

NO YES: (who): _____

2. Do you have moderate to severe asthma, a heart condition, diabetes, pre-existing kidney disease, or weakened immune system?

NO YES: (explain): _____

3. Have you been diagnosed or tested positive for COVID-19 infection? NO YES (date): _____
if yes, please answer the following:

a. During the infection did you suffer from chest pain, pressure, tightness or heaviness, or experience difficulty breathing or unusual shortness of breath?

NO YES: (explain): _____

b. Since the infection, have you had new chest pain or pressure with exercise, new shortness of breath with exercise or decreased exercise tolerance?

NO YES: (explain): _____

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

****This completed form must be turned in to Westview Athletics with your Physical paperwork****



PRE-PARTICIPATION PHYSICAL EVALUATION

Complete using **BLUE** or **BLACK** ink.

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

Student Name:		Date of Birth:	Age:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
EXAMINATION					
SPORT(S):					
Height:	Weight:	BP: / (sitting, left arm)	Pulse:	BMI % (optional): {Body Mass Index}	Vision: R 20/ L 20/ Corrected <input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL	Normal	Abnormal Findings/ Recommendations
Appearance (to include general congenital/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 monthly cancer self-exam

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(s) _____

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. I have reviewed the attached health history and COVID19 questionnaire and 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** _____

*Do not sign without Student's Name filled in. Date Physician Signed

**Physician's Stamp Here

** Print Physician NAME if not on Physician Stamp

** Print Physician PHONE if not on Physician Stamp



MEDICAL INFORMATION RELEASE FORM FOR CO-CURRICULAR ACTIVITY

Complete using **BLUE** or **BLACK** ink.

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.**

This 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:	High School Graduating Class of (Year):
Address:	Sibling Cell Phone:
City/ZIP:	Parent/Guardian (1) Cell Phone:
Date of Birth: Age:	Parent/Guardian (2) Cell Phone:

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 #:
#1 Emergency Person to Contact:	Phone #:
Relationship to Student:	
#2 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 TO CARRY MEDICATION (H-26b) or (H-58) 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.

Insurance Carrier

Policy/Group Number {If SSN, provide only last 4-digits}

X _____
SIGNATURE Parent/Guardian Date

PRINTED Name of Parent/Guardian