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 {required}:	Parent/Guardian {2} Name/Cell Phone {optional}:
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 #**:

1. I am the ☐ 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 9th Grader ☐ New Resident ☐ Administrative Placement ☐ Intra-District Transfer ☐ Inter-District Transfer
4. School attended last year:

   _____ _____ _____
   Name of School Address City/State/Zip

   _____
   Sport(s) played at previous school and level of play (varsity, JV, freshman)
5. **NEW and/or INCOMING to Westview, and/or a TRANSFER from a high school other than Westview? Complete items a through d:**
   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
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 _____ _____ **X** _____ _____
Signature of Person with Whom Student/Athlete Resides Date **Student/Athlete Signature** Date

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By signing initials below, I acknowledge that I have reviewed and agree to abide by the guidelines/policies in the Athletic Handbook, which is posted on the Westview Athletics website. I agree that the safety of the athletes always come first, and have read the information regarding health & safety. I understand signs and symptoms of a Concussion, Heat Illness, Sudden Cardiac Arrest, COVID-19 and Opioid addiction and support the decision that any athlete displaying signs or symptoms may not return to participation until medically cleared. I agree to uphold the Poway Unified School District Hazing 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. I accept and understand CIF-San Diego Section ETHICS IN SPORTS Policy posted within the Athletic Handbook and the cifsds.org website. I agree to abide by these policies while participating and/or spectating at CIFSDS athletic events regardless of contest site or jurisdiction.

ATHLETIC HANDBOOK: **Parent/Guardian Initials** _____ **Student/Athlete Initials** _____

CIF CONCUSSION INFORMATION: **Parent/Guardian Initials** _____ **Student/Athlete Initials** _____

CIF SUDDEN CARDIAC ARREST INFORMATION: **Parent/Guardian Initials** _____ **Student/Athlete Initials** _____

ATHLETIC POLICY AGAINST HAZING**: Parent/Guardian Initials** _____ **Student/Athlete Initials** _____

ETHICS IN SPORTS POLICY**: Parent/Guardian Initials** _____ **Student/Athlete Initials** _____

OPIOID FACT SHEET: **Parent/Guardian Initials** _____ **Student/Athlete Initials** _____

HEAT ILLNESS PREVENTION FACT SHEET: **Parent/Guardian Initials** _____ **Student/Athlete Initials** _____

COVID-19 INFORMATION SHEET: **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_____ **X**_____
Parent/Guardian Signature **Date** **Student/Athlete Signature** **Date**

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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*.}

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

    [ ] Mononucleosis [ ] Diabetes [ ] Measles [ ] Hernia(s) [ ] Ulcers [ ] Dental Issues
    [ ] Hepatitis [ ] Headaches [ ] Asthma [ ] Use Inhaler [ ] Rheumatic Fever
    [ ] Eye injuries [ ] Wear corrective lenses/glasses for vision [ ] Sickle cell trait/disease
    [ ] Ear injuries/Hearing loss [ ] Tuberculosis [ ] Kidney/Bladder [ ] 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.]

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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 #**:

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:	☐ Male ☐ Female

EXAMINATION

SPORT(S):

Height: Weight:	BP: / (sitting, left arm)	Pulse:	BMI % (optional): {Body Mass Index}	Vision: R 20/ L 20/ Corrected ☐ Yes ☐ 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 <u>all sports</u> 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 <u>examined by me</u> 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**

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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 {required}:
Date of Birth: Age:	Parent/Guardian (2) Cell Phone {optional}:

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**) **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**

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 based on actual or perceived ancestry, age, color, disability, gender, gender identity, gender expression, nationality, race or ethnicity, religion, sex, sexual orientation, or association with a person or a 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 Support Services, Poway Unified School District, 15250 Avenue of Science, San Diego, CA 92128-3406, 858-521-2800, extension 2761.