POWAY UNIFIED SCHOOL DISTRICT
ATHLETIC SCREENING HISTORY & PHYSICAL EXAM

The Poway Unified School District (PUSD) is an equal opportunity employer/program and is committed to an active Nondiscrimination Program. PUSD does not discriminate on the basis of race, color, national origin, sex, sexual orientation, ethnic group identification, ancestry, religion, gender, gender identification, mental or physical disability. All course offerings, student clubs, and extracurricular activities are open to all students. For more information, please contact the Associate Superintendent, Personnel Support Services, Poway Unified School District, 15250 Avenue of Science, San Diego, CA 92128-3406

☐ Del Norte HS ☐ Mt. Carmel HS ☐ Poway HS ☐ Rancho Bernardo HS ☐ Westview HS

Student Name:	Student ID#:	Date of Birth:	
Parent Name/Cell #:	Home Phone:	Grade:	☐ Male ☐ Female
Address:	City/Zip:	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 or 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** _____ **Student/Athlete 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 coach instructions regarding playing techniques, training, equipment and other team rules, etc. both in competition and practice and agree to obey such instructions. **Parent Initials** _____ **Student/Athlete 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 or daughter in the event of any 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 medical treatment beyond basic first aid. **Parent Initials** _____ **Student/Athlete 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 or daughter, and that this coverage will remain in effect throughout the time that he or 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.
NAME of Insurance Carrier _____ **Policy/Group #** _____ **Parent Initials** _____ **Student/Athlete Initials** _____

MEDIA RELEASE

I understand that my name, picture, and/or grade point average may be released to the media. **Parent Initials** _____ **Student/Athlete Initials** _____

REFER TO ATHLETIC HANDBOOK FOR THIS SECTION LOCATED ON SCHOOL WEBSITE UNDER ATHLETICS

ATHLETIC HANDBOOK

I have reviewed and agree to abide by the guidelines/policies in the Athletic Handbook which is posted on school website. By signing below, I acknowledge that it is my responsibility to read and understand these rules and discuss them with my parent/guardian/athlete. **Parent 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 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 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. 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. **Parent Initials** _____ **Student/Athlete Initials** _____

ETHICS IN SPORTS POLICY

I read and 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. I agree to abide by this policy while participating and/or spectating at CIFSDS athletic events regardless of contest site or jurisdiction. **Parent Initials** _____ **Student/Athlete Initials** _____

SUDDEN CARDIAC ARREST

I agree that the safety of the athletes always come first. I have read the Sudden Cardiac Arrest information Sheet and am familiar with the signs and symptoms of SCA. . I understand and support the decision that any athlete suspected of suffering sudden cardiac arrest may be removed from a game or practice immediately and will not be allowed to return to activity until medically cleared. **Parent Initials** _____ **Student/Athlete Initials** _____

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

Print Student/Athlete Name _____

X _____
Student/Athlete Signature

Print Parent/Guardian Name _____

X _____
Parent/Guardian Signature

CIF-SAN DIEGO SECTION
RESIDENCE & ELIGIBILITY VERIFICATION
Athletic/Extracurricular Participation

** To be completed by individual with whom student resides**

Pursuing Victory with Honor

Student Name:	Grade:	Sport(s):
Address:	DOB:	Parent Cell #:
Home Phone #:	Age:	Parent Cell #:

1. I am the one with whom this student-athlete **resides**: (check one box)

   ☐ Parent ☐ Legal Guardian ☐ Relative ☐ Caretaker ☐ Foster Parent ☐ Emancipated Minor

2. I AFFIRM THAT THIS STUDENT RESIDES AT THE FOLLOWING ADDRESS:

   _____
   Street Address

   _____ (_____)_____
   City/State/Zip Telephone

   PARENTS' ADDRESS (if different than listed in #2)

   _____ _____
   Mother's Street Address City/State/Zip

   _____ _____
   Father's Street Address City/State/Zip

3. Student Status:

   ☐ Continuing Student ☐ Incoming 9th Grader ☐ New Resident ☐ Administrative Placement ☐ Intra-District Transfer ☐ Inter-District Transfer

4. School(s) Attended Last Year

Name of School	Address	City/State/Zip	Sports(s) Played
Name of School	Address	City/State/Zip	Sports(s) Played

5. I understand that this street address is within the High School boundaries and/or I have followed the District transfer procedures.
   I also understand that falsifying this information will cause team forfeiture and immediate ineligibility.

   _____
   Print Name of Person Checked on Line 1

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

THIS SECTION IS TO BE COMPLETED BY ALL NEW STUDENTS, INCOMING 9th GRADERS AND ALL TRANSFER STUDENTS

State CIF Bylaws require that all information provided in regard to any aspect of student eligibility to participate in athletics must be true, correct, accurate, and complete. State CIF Bylaws also require that parents, students, coaches and schools must disclose any pre-enrollment contact of any kind whatsoever with the parent or student during the 24 months prior to enrollment in the school.
I understand that it is my responsibility to see the Athletic Director to receive the CIF San Diego Section Transfer Student Eligibility forms prior to athletic participation. **Check one:**

☐ There has been no pre-enrollment contact of any kind whatsoever during the previous 24 months with anyone at or associated with the school or its athletic programs.

☐ There has been pre-enrollment contact during the previous 24 months with individuals at or associated with the school and its athletic programs by: (check all that apply) ☐ Clubs ☐ Camps ☐ 8th Grade Parent Night ☐ Conversation with High School Coach.

A true, correct, and complete disclosure of that contact is written on the back or attached to this form.

PRE-PARTICIPATION PHYSICAL EVALUATION
MEDICAL HISTORY

(This form is to be completed by the patient and parent prior to seeing the physician. Submit original to school Athletics Office. Physician should retain a copy.)

☐ Mt. Carmel HS ☐ Del Norte HS ☐ Poway HS ☐ Rancho Bernardo HS ☐ Westview HS

Student Name:	Student ID #:	☐ Male ☐ Female
Sport(s):	Date of Birth:	Grade: Age:

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify allergy ☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other:		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
5. Do you have any physical or mental impairment which may affect your participation in athletics or may require accommodations?		
HEART HEALTH QUESTIONS ABOUT YOU		
6. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
7. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
8. Does your heart ever race or skip beats (irregular beats) during exercise?		
9. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ High cholesterol ☐ Kawasaki disease ☐ A heart murmur ☐ A heart infection Other:		
10. Has a doctor ever ordered a test for your heart? ECG/EKG, echocardiogram?		
11. Do you get lightheaded or feel short of breath during exercise?		
12. Have you ever had an unexplained seizure?		
13. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		
14. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?		
15. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
16. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
17. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS		
18. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
19. Have you ever had broken or fractured bones or dislocated joints?		
20. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
21. Have you ever had a stress fracture?		
22. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
23. Do you regularly use a brace, orthotics, or other assistive device?		
24. Do you have a bone, muscle, or joint injury that bothers you?		
25. Do any of your joints become painful, swollen, feel warm, or look red?		
26. Do you have any history of juvenile arthritis or connective tissue disease?		
27. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
28. Have you ever used an inhaler or taken asthma medicine?		
29. Is there anyone in your family who has asthma?		

MEDICAL QUESTIONS	Yes	No
30. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
31. Do you have groin pain or a painful bulge or hernia in the groin area?		
32. Have you had infectious mononucleosis (mono) within the last 3 months?		
33. Do you have any rashes, pressure sores, or other skin problems?		
34. Have you had a herpes or MRSA skin infection?		
35. Have you ever had a head injury or concussion?		
36. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
37. Do you have a history of seizure disorder?		
38. Do you have headaches with exercise?		
39. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
40. Have you ever been unable to move your arms or legs after being hit or falling?		
41. Have you ever become ill while exercising in the heat?		
42. Do you get frequent muscle cramps when exercising?		
43. Do you or someone in your family have sickle cell trait or disease?		
44. Have you had any problems with your eyes or vision?		
45. Have you had any eye injuries?		
46. Do you wear glasses or contact lenses?		
47. Do you wear protective eyewear, such as goggles or a face shield?		
48. Do you worry about your weight?		
49. Are you trying to or has anyone recommended that you gain or lose weight?		
50. Are you on a special diet or do you avoid certain types of foods?		
51. Have you ever had an eating disorder?		
52. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
53. Have you ever had a menstrual period?		
54. How old were you when you had your first menstrual period?		
55. How many periods have you had in the last 12 months?		

EXPLAIN "YES" answers here with dates and details: (Attachment ok if necessary)

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

X _____ _____ X _____ _____

Student/Athlete Signature **Date** **Parent/Guardian Signature** **Date**

PRE-PARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

(This form is to be completed by the physician. Submit **ORIGINAL** to school Athletics Office. Physician should retain a copy.)

Student Name:	Date of Birth: Age:	☐ Male ☐ Female
EXAMINATION		
Height: Weight:	BMI: BP: / Pulse:	Vision: R 20/ L 20/ Corrected ☐ Yes ☐ No

MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyper		
Eyes/Ears/Nose/Throat • Pupils Equal • Hearing		
Lymph Nodes		
Heart • Murmurs (auscultation standing, supine, +/- Valsalva • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin • HSV, lesions suggestive of MRSA, tlnea corporis		
Neurologic		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Angle		
Foot/Toes		
Functional • Duck-walk, single leg hop		

☐ **CLEARED for all sports WITHOUT restriction**.

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for

_____

☐ **NOT CLEARED**: ☐ Pending further evaluation ☐ For any sports ☐ For certain sport _____

REASON: _____

Recommendations _____

_____

(Student's name) _____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. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. 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.

Print Physician's Name: _____ **Phone Number:** _____

Physician's Signature: X _____ **Physician's Office Stamp HERE** →

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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:	Sport(s):
Parent/Guardian Name:	Graduating Year:
Address:	City/ZIP
Home Phone:	Mother Cell: Mother Work:
	Father Cell: Father Work:

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 #:
Emergency Person to Contact:	Phone #:
Relationship to Student:	
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 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**

Revised 12/16/15

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POWAY UNIFIED SCHOOL DISTRICT
ADDITIONAL MEDICAL INFORMATION

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:	Student ID #:	□ Male	□ Female
Sport(s):	Date of Birth:	Grade:	Age:

IN CASE OF EMERGENCY, A REPRESENTATIVE OF THE PUSD ATHLETIC DEPARTMENT HAS THE AUTHORITY TO SECURE MEDICAL OR SURGICAL TREATMENT AND TRANSPORT AS NECESSARY.

If information is not applicable, please write N/A in spaces provided below.

Forms on file with DNHS Health Office (please list all):*	**Medication kept on site in DNHS Health Office (please list all)**:
	Medication kept with student (please list all):
***Please provide a copy of the General Health Medical Plan.**	
The Athletic Trainer CANNOT give over the counter (OTC) medication to any student or student athlete under any circumstances at any time.	

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 hereby state that, to the best of my knowledge, the information I have provided is complete and correct.

_____ _____

Print Student/Athlete Name **Print Parent/Guardian Name**

X_____ **X**_____

Student/Athlete Signature **Parent/Guardian Signature**

Revised 4/2/18