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.]

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, tlnea 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

_____

**** Print Physician NAME if not on Physician Stamp**

_____

**** Print Physician PHONE if not on Physician Stamp**

**Physician's Stamp Here