William S. Hart Union High School District

CERTIFICATE OF PHYSICAL EXAMINATION

Name_____DOB____/____/____

Height_____Weight_____Pulse_____BP_____/_____

Please place a "✓" as either Normal or Abnormal for all findings below. Please describe in detail all abnormal findings.

	Normal	Abnormal	Comments
Heart			
Pulses			
Lungs			
Neck			
Back			
Shoulder/Arm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle/Foot			
Other pertinent medical findings			

Additional comments:_____

_____

_____

List any restrictions and duration:_____

_____

I hereby certify that_____was examined by me on_____20____

and found him/her to be physically fit to engage in athletics.

Physician's Signature_____Date_____

Stamp name or attach card of medical office here:

Medical history form to be completed by parent/guardian before physical exam.

William S. Hart Union High School District

MEDICAL HISTORY TO BE COMPLETED BY PARENT/GUARDIAN BEFORE PHYSICAL EXAM

Name of Student-Athlete_____Sex_____Age_____DOB_____

Graduation Year _____School_____Castaic High School_____Sport(s) _____

Year that student will graduate high school (ex. "2023")

Check **Yes** or **No** (If "Yes" explain)

1. Has the student-athlete had a medical illness or injury since his/her last check up or sport physical? Y ☐ N ☐

Date of Incident: Type of Illness or Injury:

2. Is the student-athlete currently taking any prescription or nonprescription (over-the-counter) medication or using an inhaler? Y ☐ N ☐

Type of Medication:

3. Does the student-athlete have any allergies (for example, pollen, medicine, food, or stinging insects)? Y ☐ N ☐

Type of Allergy:

4. Has the student-athlete ever had a seizure? Y ☐ N ☐

Date of Incident(s):

5. Has the student-athlete ever become ill from exercising in the heat? Y ☐ N ☐

Date of Last Incident:

6. Is there any pertinent medical information coaches or physicians should know about the athlete? Y ☐ N ☐

Explain:

7. Does the student-athlete wear glasses, contacts, or dental braces? Y ☐ N ☐

Explain:

8. Has the student-athlete ever been diagnosed with a concussion? Y ☐ N ☐

Date of Incident(s):

Please indicate the longest amount of time the student-athlete has missed activity due to a concussion:

_____ _____

Parent/Guardian Signature Date

Henry Mayo
Newhall Hospital

AUTHORIZATION FOR SPORTS MEDICINE SERVICES AND CONSENT FOR TREATMENT

I, the undersigned, am the parent/legal guardian of, _____, a minor and
Student-Athlete Name- Print

student-athlete at _____ who plans on participating in _____
Name of School Sport

I, hereby give consent for a certified Athletic Trainer, an employee of Henry Mayo Newhall Hospital, and/or other Henry Mayo Newhall Hospital clinical staff, who is contracted by the school to provide sports medicine services for the above minor. Sports medicine services include, but are not limited to: administrating first aid for athletic injuries, providing initial treatment and management of acute injuries, and assessing athletic injuries at the request of the athlete, the athlete's coach, or the athlete's parent/guardian. The Athletic Trainer and/or sports medicine clinical staff will perform only those procedures that are within their training, credential limitations and scope of professional practice to prevent, care for and rehabilitate athletic injuries. I understand that a written report of any athletic injury assessment will be confidentially maintained in the files of the training room or school nurse's office.

I, hereby authorize the Athletic Trainer and/or other Henry Mayo Newhall Hospital clinical staff who provide services to the above-named athlete to disclose information about the injury assessments and post injury status. This will be done as needed, with the coaching staff, Athletic Director of the school and if necessary; the school nurse, any treating healthcare provider and/or consulting concussion management specialist.

I understand that there is no charge to me for the above listed athletic training services. If the athlete is in need of further treatment by a physician, or of rehabilitation services for the injury, he or she may see the physician or provider of his/her choice. Injured athletes that have seen a physician must submit written clearance from that physician to the Athletic Trainer prior to being permitted to resume activity. This authorization shall remain in effect for one sports season beginning with the date set forth below.

Parent/Guardian Name (print) _____ Signature _____ Date _____

Relationship to student-athlete _____ Cell/Work phone _____

Home Address _____ Home Phone _____

Student-Athlete Name (print) _____ Sex ___ Grade ____ Date of Birth _____

Allergies _____

Current Medications (i.e. asthma inhaler, epi-pen, etc) _____

Physical Impairments _____

Other pertinent medical history (surgeries, diabetes, seizures, heart condition, etc.) _____

_____

_____

Physician Name _____ Physician Phone _____