VISTA UNIFIED SCHOOL DISTRICT

Athletic Screening History & Physical Exam

Please indicate:

☐ Mission Vista HS ☐ Rancho Buena Vista HS ☐ Vista HS

Student Name:	Student ID #:
Address:	Date of Birth:
City/Zip:	Graduating Year:
Home Phone:	Parent Name / Cell # :
Emergency Contact / Phone:	Parent Name / Cell # :

EXPLANATION OF SCREENING PHYSICAL

I realize that the medial 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.

Parents 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 participant 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 participant 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.

Parents Initials _____

PERMISSION FOR TREATMENT

I hereby grant permission to the Athletic Trainer, Team Physicians and those professional personnel designated by Vista 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 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 medial treatment beyond basic first-aid.

Parents Initials _____

PROOF OF INSURANCE

In compliance with California Education Code 32221, I certify that there s in effect at this time insurance coverage for medial 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 supervision school transportation.

Parents Initials _____ Insurance Carrier _____ Policy # _____

I have read the above statement, EXPLANATION OF SCREENING PHYSICAL, AWARNESS OF RISKS, and PERMISSION FOR TREATMENT, and understand them fully and agree/consent to their contents.

Parent Signature: _____ Date: _____

Student Signature: _____ Date: _____

Student Name: _____

Health History - Please answer the following in the check box provided. Explain "yes" answers in the box below.

1. Have you ever been hospitalized (overnight)? [ ] Yes [ ] No

2. Have you ever had surgery? [ ] Yes [ ] No

3. Are you currently taking medication? [ ] Yes [ ] No

4. Do you have any allergies (medicines, pollen, bees)? [ ] Yes [ ] No

5. Have you ever passed out during exercise? (not from heat) [ ] Yes [ ] No

6. Have you ever been dizzy during exercise? (not from heat) [ ] Yes [ ] No

7. Have you ever had chest pain? [ ] Yes [ ] No

8. Do you tire more quickly than your friends during exercise? [ ] Yes [ ] No

9. Have you ever had high blood pressure? [ ] Yes [ ] No

10. Have you ever been told you had a heart murmur? [ ] Yes [ ] No

11. Have you ever had racing of your heart or skipped beats? [ ] Yes [ ] No

12. Has anyone in your family died of heart problems or a sudden death before age 40? [ ] Yes [ ] No

13. Does anyone in your family have Marfan's Syndrome? [ ] Yes [ ] No

14. Do you have any skin problems (itching, rashes, breaking out)? [ ] Yes [ ] No

15. Have you ever had a head injury? [ ] Yes [ ] No
    Have you ever been knocked out? [ ] Yes [No
    Have you ever had a seizure? [ ] Yes [ ] No
    Have you ever had a burner/stinger? (pain from neck to arm) [ ] Yes [ ] No

16. Have you ever had heat cramps? [ ] Yes [ ] No
    Have you ever been dizzy or passed out in the heat? [ ] Yes [ ] No

17. Do you use special pads or orthotic braces? [ ] Yes [ ] No

18. Have you ever injured (broken/fractured, sprained, dislocated)?
[ ] Hand / fingers [ ] Shoulder [ ] Hip [ ] Shin / calf [ ] Wrist / forearm [ ] Neck [ ] Thigh
[ ] Ankle [ ] Elbow [ ] Chest/ribs [ ] Knee [ ] Foot / toes [ ] Upper arm [ ] Back
[ ] Stress fractures?

19. Have you ever had?
[ ] Mononucleosis [ ] Diabetes [ ] Hepatitis [ ] Headaches (frequent) [ ] Eye/ear injuries
[ ] Tuberculosis [ ] Measles [ ] Hernia(s) [ ] Asthma [ ] Ulcers
[ ] Sickle cell trait/disease

20. When was your last tetanus shot? _____

21. About your weight: Do you think you are . . . [ ] just Right? [ ] too Heavy? [ ] too Thin / Light?
    For females: Are your periods [ ] Regular/monthly? [ ] Irregular / skip months?

When was your first period and how old were you? _____ When was your last period? _____

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

Please Explain and "YES" answers here:

Student Name: _____

Circle the sport(s) you will be participating in:

Baseball	Basketball	Cheerleading	Cross Country	Field Hockey
Football	Golf	Soccer	Softball	Swimming
Track/Field	Tennis	Volleyball	Water Polo	Wrestling

Physical Examination

(To be completed by Medical Personnel)

Height _____

Weight _____

Blood Pressure _____
(sitting, left arm)

Pulse _____

Vision (optional)
Left eye 20 / _____
Right eye 20 / _____
Both eyes 20 / _____

with / without glasses

1. Skin	
2. Head	
3. Eyes (PERLA, EOMI, Fundi)	
4. Ears nose, throat	
5. Neck	
6. Lymphatic	
7. Respiratory	
8. Cardiovascular Heart (murmurs)?	
9. Abdomen	
10. Extremities	
11. Neurological Reflexes	
12. Orthopedic	
Cervical spine/back	
Arms/elbows/wrist/hands	
Hips	
Knees	
Ankles/feet	

√ = within normal limits **+ = see comments** **X= omitted**

Comments / Recommendations:

Student Name: _____

MEDICAL CLEARANCE

(As appropriate for age and development)

[ ] Full contact/collision level (full, unrestricted participation)

[ ] Limited contact / impact

[ ] Non contact: strenuous

[ ] Non contact: non-strenuous

[ ] Clearance deferred or no participation at this time because:

[ ] Needs clearance by specialist

[ ] Orthopedist [ ] Cardiologist

Other : _____

[ ] Needs to complete rehabilitation for current condition(s) prior to participation

Physician's Statement:

(Student's name) _____ was examined by me on _____(date) and found physically fit to engage in high school athletics. Results are to encourage, but in no way guarantee, the fitness and safety of this athlete.

Practitioner signature: _____ Date: _____

M.D. / D.O. / N.P. / P.A. / D.C.

Do not sign without student's name filled in

Physician's Office Stamp HERE (REQUIRED)