



## 2022-2023 Delta Charter Schools Physical Examination and Clearance Form



### Check your sports:

#### FALL

- ☐ Cross Country  
☐ Girls Volleyball  
☐ Football

#### WINTER

- ☐ Basketball  
☐ Soccer  
☐ Wrestling

#### SPRING

- ☐ Baseball  
☐ Boys Volleyball  
☐ Cheer  
☐ Golf  
☐ Softball  
☐ Track and Field

Student last name: \_\_\_\_\_ Grade: \_\_\_\_\_

Student first name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_

Parent/guardian name: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/guardian email: \_\_\_\_\_

Has student attended any other high school? ☐ Yes ☐ No

If so, name of high school: \_\_\_\_\_

**This medical history and examination is only intended to determine ability to participate in sports and is not a substitute for regular examinations by your physician.**

Have you ever had any of the following (please circle Y or N):

YES	NO		YES	NO	
<input type="checkbox"/> Y	<input type="checkbox"/> N	Head injury	<input type="checkbox"/> Y	<input type="checkbox"/> N	Anemia, leukemia or other blood disorder
<input type="checkbox"/> Y	<input type="checkbox"/> N	Back or neck problems or curvature of the spine	<input type="checkbox"/> Y	<input type="checkbox"/> N	Diabetes
<input type="checkbox"/> Y	<input type="checkbox"/> N	Broken bones, dislocations, or amputations	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hernia, kidney problem, testicle problem
<input type="checkbox"/> Y	<input type="checkbox"/> N	Polio or programs with feet, knees, or other joints	<input type="checkbox"/> Y	<input type="checkbox"/> N	Enlarged spleen or liver
<input type="checkbox"/> Y	<input type="checkbox"/> N	Eye injury, eye surgery, eye disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Surgery other than tonsils
<input type="checkbox"/> Y	<input type="checkbox"/> N	Wear glasses, contacts, hearing aids or dentures	<input type="checkbox"/> Y	<input type="checkbox"/> N	Family history of sudden death
<input type="checkbox"/> Y	<input type="checkbox"/> N	Headaches other than minor headaches	<input type="checkbox"/> Y	<input type="checkbox"/> N	Presently taking medication (list below)
<input type="checkbox"/> Y	<input type="checkbox"/> N	Drug addiction, mental illness, nervous disorder	<input type="checkbox"/> Y	<input type="checkbox"/> N	Allergic to medicine, foods, bee stings, etc.
<input type="checkbox"/> Y	<input type="checkbox"/> N	Epilepsy, fainting, or dizzy spells	<input type="checkbox"/> Y	<input type="checkbox"/> N	Do you have any ongoing medical problems
<input type="checkbox"/> Y	<input type="checkbox"/> N	Lung trouble, shortness of breath, asthma	<input type="checkbox"/> Y	<input type="checkbox"/> N	Do you know any reason why you should not participate in sports
<input type="checkbox"/> Y	<input type="checkbox"/> N	Heart trouble, rheumatic fever			

Current medications: \_\_\_\_\_

### PHYSICIAN'S PHYSICAL EXAMINATION\*

Date: \_\_\_\_\_ B/P: \_\_\_\_\_ SEX: M or F Weight: \_\_\_\_\_ Height: \_\_\_\_\_

I have examined this student and have found her/him (check one): ☐ Fit for Sports ☐ In need of further evaluation

Reason for further evaluation: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Physician Stamp Here

Office Phone: \_\_\_\_\_ Date: \_\_\_\_\_

*\* Physical good for one calendar year from date of examination.*

### MEDICAL INSURANCE

California law (Education Code Sections 3220-21) requires every member of any interscholastic athletic team, as well as those associated directly with any interscholastic team, athletic event, including song and cheerleaders, team mascots, team managers, etc. to possess accidental bodily insurance providing at least \$1500 of scheduled medical and hospital benefits. Please specify on the form below the required insurance coverage that you have provided for your child. You will promptly notify the school in the event insurance coverage no longer applies to your child.

Insurance Company Name

Group or Policy Number



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**EMERGENCY CONTACT**

Name: \_\_\_\_\_

Phone: \_\_\_\_\_