TRAVIS UNIFIED SCHOOL DISTRICT
Reaching beyond the boundaries to build a community of learners.

# TRAVIS UNIFIED SCHOOL DISTRICT
# SPORTS PHYSICAL EXAMINATION FORM

## PART 1 (TO BE COMPLETED BY A PARENT OR LEGAL GUARDIAN)

| LAST NAME | FIRST NAME | GRADE |
|---|---|---|
| | | |

| BIRTHDATE | FALL SPORT | WINTER SPORT | SPRING SPORT | **STUDENT ID NUMBER** |
|---|---|---|---|---|
| | | | | |

## PART 1 -- HEALTH HISTORY (Must be Completed by Parent/Guardian Prior to the Examination)

| | Yes | No | **Has this student had:** |
|---|---|---|---|
| 1. | ☐ | ☐ | Chronic or recurrent illness? |
| 2. | ☐ | ☐ | Illness lasting over 1 week? |
| 3. | ☐ | ☐ | Hospitalizations or Surgeries? |
| 4. | ☐ | ☐ | Nervous, psychiatric, or neurologic condition? |
| 5. | ☐ | ☐ | Loss or nonfunctioning of organs (eye, kidney, liver, testicle) or glands? |
| 6. | ☐ | ☐ | Allergies (medicines, insect bites, food)? |
| 7. | ☐ | ☐ | Problems with heart or blood pressure? |
| 8. | ☐ | ☐ | Chest pain, significant or severe shortness of breath, during or after exercise? |
| 9. | ☐ | ☐ | Dizziness or fainting with/after exercise? |
| 10. | ☐ | ☐ | Fainting, bad headaches or convulsions? |
| 11. | ☐ | ☐ | Potential concussion or loss of consciousness? |
| 12. | ☐ | ☐ | Heat exhaustion, heatstroke, or other problems managing or responding to heat? |
| 13. | ☐ | ☐ | Racing heartbeat, skipped or irregular heartbeats, or heart murmur? |
| 14. | ☐ | ☐ | Seizures or seizure disorders? |
| 15. | ☐ | ☐ | Severe or repeated instances of muscle cramps? |
| 16. | ☐ | ☐ | Injuries requiring medical care or treatment? |
| 17. | ☐ | ☐ | Neck or back pain or injury? |
| 18. | ☐ | ☐ | Knee pain or injury? |
| 19. | ☐ | ☐ | Shoulder or elbow pain or injury? |
| 20. | ☐ | ☐ | Ankle pain or injury? |
| 21. | ☐ | ☐ | Other joint pain or injury? |
| 22. | ☐ | ☐ | Broken bones (fractures)? |

| | Yes | No | **Does this student presently:** |
|---|---|---|---|
| 23. | ☐ | ☐ | Wear eyeglasses or contact lenses? |
| 24. | ☐ | ☐ | Wear dental bridges, braces or plates? |
| 25. | ☐ | ☐ | Take any medications? (List below): |

| | Yes | No | **Further history:** |
|---|---|---|---|
| 26. | ☐ | ☐ | Birth defects (corrected or not)? |
| 27. | ☐ | ☐ | Death of a parent or grandparent less than 40 years of age due to medical cause or condition? |
| 28. | ☐ | ☐ | Parent or grandparent requiring treatment for heart condition less than 50 years of age? |
| 29. | ☐ | ☐ | Been seen by a physician on an emergency or urgent basis in the last 12-months? |

*Date of last known tetanus (lockjaw) shot:* _____ *Date of last complete physical examination:* _____

*Explain all "YES" answers. Describe any other fact that should be disclosed prior to the examination (use reverse of form if needed):*

**PARENT/GUARDIAN'S AUTHORIZATION:** I authorize the health care provider to perform a Sports Physical Evaluation on the student. The information above is complete and accurate. I presently know of no reason why the student cannot fully and safely participate in the listed sports. For Sports Physical Evaluations that may be performed by District volunteers, I understand the evaluation is a screening evaluation only, and that I must address all health care concerns with the Student's personal physician or health care provider.

| PRINT NAME OF PARENT OR GUARDIAN | SIGNATURE OF PARENT OR GUARDIAN | | |
|---|---|---|---|
| | | | |
| ADDRESS | WORK PHONE | HOME PHONE | DATE |
| | | | |
| REGULAR PHYSICIAN'S NAME | OFFICE PHONE | | |
| | | | |

## PART 2 – MEDICAL EVALUATION (TO BE COMPLETED BY THE EXAMINING HEALTH CARE PROVIDER)

**This Evaluation Can Only be Performed by Properly Training Medical Doctors (MDs), Doctors of Osteopathy (DOs), Physician's Assistants (P.A.s), or Nurse Practitioners (N.P.s)**

| | Normal | Abnormal (Describe) |
|---|---|---|
| Eyes/Ears/Nose/Throat | | |
| Heart, lungs, pulmonary function | | |
| Abdomen, genital/hernia (males) | | |
| Skin and Musculoskeletal: | | |
| a. Neck/Spine/Shoulders/Back | | |
| b. Arms/Hands/Fingers | | |
| c. Hips/Thighs/Knees/Legs | | |
| d. Feet/Ankles | | |
| Neurologic Screening Exam (NSE) | | |
| Sudden Cardiac Arrest Screening/Review | | |
| Concussion Screening Eval. (if needed) | | |

**(May be contained on Provider's Form)**

Height: Weight:

Pulse: After Ex:

BP:

**Recommendation:**

☐ Unlimited participation

☐ Limited participation/specific sports, events or activities

☐ Clearance withheld pending further testing/evaluation

☐ No athletic participation

One of the above MUST be checked.

**Comments:**

| PRINT NAME OF PHYSICIAN | PHYSICIAN'S SIGNATURE | DATE |
|---|---|---|
| | | |

Original to be held on file for a period of one (1) year after the end of the Academic Year (Ed. July 2017)

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