

**HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT
ANNUAL PHYSICAL SCREENING FORM**



SPORTS: (fall) _____ (winter) _____ (spring) _____

Name _____ Grade 0 Male Female Date of birth ___/___/___

Address _____ City & Zip Code _____ Home Phone _____

Name of Father/Guardian _____ Work phone _____ Cell phone _____

Name of Mother/Guardian _____ Work phone _____ Cell phone _____

Emergency Contact _____ Phone Number _____ Insurance _____

I hereby give my consent for the above named student (son/daughter/ward) to compete in sports and to go with a representative of the school on any trips. In case of injury, you are authorized to have him/her treated.

Signature of parent/guardian _____ Date _____

HEALTH HISTORY: TO BE COMPLETED BY PARENT BEFORE DOCTOR EXAM

<u>Any past or present:</u>	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Problems with vision	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Eyeglasses	<input type="checkbox"/>	<input type="checkbox"/>	Dental problems	<input type="checkbox"/>	<input type="checkbox"/>
Contacts	<input type="checkbox"/>	<input type="checkbox"/>	braces	<input type="checkbox"/>	<input type="checkbox"/>
Problems with hearing	<input type="checkbox"/>	<input type="checkbox"/>	false teeth	<input type="checkbox"/>	<input type="checkbox"/>
Hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	Painful joints	<input type="checkbox"/>	<input type="checkbox"/>
Blacking out or fainting	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones	<input type="checkbox"/>	<input type="checkbox"/>
Unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>	Part, date _____		
Convulsions, seizures	<input type="checkbox"/>	<input type="checkbox"/>	Knee or ankle problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Require support/brace	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Need for medication	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	Name _____		
Blood sugar problems	<input type="checkbox"/>	<input type="checkbox"/>	Menstruation problems	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Hernias	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Allergies - type _____			OTHER HEALTH ASPECTS THE DOCTOR AND SCHOOL SHOULD BE AWARE OF:		
Bee or insect stings	<input type="checkbox"/>	<input type="checkbox"/>			
Hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>			

PHYSICAL EXAM: DATE _____ HEIGHT _____ WEIGHT _____

PULSE: RESTING _____ AFTER ACTIVITY _____ B.P. _____

EYES	_____	LYMPH GLANDS	_____	POSTURE	_____
EARS	_____	THYROID	_____	MUSCLE TONE	_____
NOSE	_____	HEART	_____	REFLEXES	_____
THROAT	_____	LUNGS	_____	ORTHOPEDIC	_____
TEETH	_____	ABDOMEN	_____	SKIN	_____
BRACES	_____	HERNIA	_____	OTHER	_____

I have examined the above student and do recommend that s/he is physically fit for full participation in sports.

Name of physician _____ MD or DO Date _____

Signature _____ Phone number _____

Special doctor recommendations or restrictions _____

****PLEASE STAMP WITH PHYSICIAN'S OFFICE STAMP****

**HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT
MEDICAL INSURANCE CERTIFICATION**



Last Name:		First Name:			MI:
Birth Date:	Sports/Activity:				
		<i>Fall</i>	<i>Winter</i>	<i>Spring</i>	

California Law, Education Code, Section 32220-24 requires that every member of a high school athletic team have accidental bodily injury insurance, providing at least \$1500 of scheduled medical/hospital benefits. The parent or guardian must provide proof that their family coverage satisfies the Code in relation to medical coverage. If you **have** the \$1500, accidental bodily injury insurance, please fill out **ITEM 1** below. If you **do not have** accidentally bodily injury benefits for your son, daughter, or ward, please fill out **ITEM 2** below.

ITEM 1 -- MY MEDICAL COVERAGE POLICY FOR AT LEAST \$1500 IS ISSUED BY:

<i>Insurance Company</i>	<i>Policy Number</i>
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I certify that the student listed above **has** accidental bodily injury insurance providing at least \$1500 of scheduled medical/hospital benefits.

<i>Student's Signature</i>	/ /	<i>Parent/Guardian Signature</i>	/ /
<i>Date</i>		<i>Date</i>	

**PROOF OF INSURANCE IS
REQUIRED PLEASE ATTACH A
PHOTOCOPY OF
INSURANCE CARD HERE**

ITEM 2

The athlete does not have accidental bodily injury insurance required. **YOU MUST COMPLETE APPROPRIATE MYERS STEVENS & TOOHEY & CO., INC. APPLICATION**

We have subscribed to Myers-Stevens & Toohey & Co., Inc for athletic insurance, which meet the limits requested. (Myers-Stevens & Toohey & Co. Inc. will send verification of insurance to each school)

<i>Student's Signature</i>	/ /	<i>Parent/Guardian Signature</i>	/ /
<i>Date</i>		<i>Date</i>	