

# Preparticipation Physical Evaluation

History

Date of exam \_\_\_\_\_

Name _____		Sex _____	Age _____	Date of Birth _____
Grade _____	School _____	Sport(s) _____		
Address _____				
Personal physician _____				
<b>In case of emergency, contact</b>				
Name _____		Relationship _____	Phone (C) _____	(W) _____

Explain "Yes" answers below.  
Circle questions you don't know the answers to.

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical? Do you have an ongoing or chronic disease?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aide)?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized overnight? Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you had any problems with your eyes or vision? Do you wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had a sprain, strain or swelling after an injury? Have you broken or fractured any bones or dislocated any joints? Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? <i>If yes, checked appropriate box and explain below.</i>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Thigh <input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Knee <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Shin/calf <input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Ankle <input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Foot <input type="checkbox"/> Upper Arm <input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out during or after exercise? Have you ever been dizzy during or after exercise? Have you ever had chest pain during or after exercise? Do you get tired more quickly than your friends do during exercise? Have you ever had racing of your heart or skipped heart beats? Have you had high blood pressure or high cholesterol? Have you ever been told you have a heart murmur? Has any family member or relative died of heart problems or of sudden death before age 50? Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	13. Do you want to weigh more or less than you do now? Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had a head injury or concussion? Have you ever been knocked out, become unconscious, or lost your memory? Have you ever had a seizure? Do you have frequent or severe headaches? Have you ever had numbness or tingling in your arms, hands, legs, or feet? Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	15. Record the dates of your most recent immunizations (shots) for: Tetanus _____ Measles _____ Hepatitis B _____ Chickenpox _____	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you have Sickle Cell Trait or Sickle Cell Disease?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you cough, wheeze, or have trouble breathing during or after activity? Do you have asthma? Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<b>FEMALES ONLY</b> 17. When was your first menstrual period? _____ When was your most recent menstrual period? _____ How much time do you usually have from the start of one period to the start of another? _____ How many periods have you had in the last year? _____ What was the longest time between periods in the last year? _____		

Explain "Yes" answers here:

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I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

# Preparticipation Physical Evaluation

## PHYSICAL EXAMINATION

Name _____	Date of Birth _____
Height _____ Weight _____ % Body fat (optional) _____	Pulse _____ BP _____ / _____ (____ / _____, ____ / _____)
Vision R 20/ _____ L 20/ _____ Corrected: Y N	Pupils: Equal _____ Unequal _____

PHYSICAL EXAMINATION			
<b>MEDICAL</b>			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

## CLEARANCE

Cleared

Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Not cleared for: \_\_\_\_\_ Reasons: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO Medical License No. \_\_\_\_\_

**WALNUT VALLEY UNIFIED SCHOOL DISTRICT  
PARENT'S OR GUARDIAN'S PERMISSION FOR STUDENT PARTICIPATION IN  
EXTRACURRICULAR/ATHLETIC ACTIVITY,  
ASSUMPTION OF RISK, AND  
HOLD HARMLESS, INDEMNITY AND RELEASE OF LIABILITY**

To the Principal of: \_\_\_\_\_ (School)

\_\_\_\_\_ has my permission to participate in  
(Student Name: please print)

\_\_\_\_\_ during the \_\_\_\_\_.  
(Extracurricular/Athletic Activity) (School Year/Semester/Quarter)

Supervising Teacher / Coach (please print): \_\_\_\_\_

**(1) Assumption of Risk:**

On behalf of student and myself:

We understand that the above-listed extracurricular/athletic activity, by its very nature, includes certain risks. The specific risks vary, but may involve minor injury, major injury, and serious injury, including permanent disability and death, and severe social and economic losses which might result not only from student's own actions, inactions, or negligence, but the actions, inactions, or negligence of others, the rules of play, or the condition of the premises or of any equipment used. **We understand and appreciate the risks that are inherent in the extracurricular/athletic activity. We hereby assert and agree, on behalf of ourselves, our family, heirs, personal representative(s), and/or assigns, that student's participation in the extracurricular/athletic activity is voluntary and that we knowingly assume all such risks of that participation. We recognize the importance of following instructions regarding proper technique, training and other established safety rules, guidelines and regulations. We agree that student will abide by all rules and regulations governing the extracurricular/athletic activity.**

**(2) Hold Harmless, Indemnity and Release:**

On behalf of student and myself, and in consideration of permission for student to participate in the above listed extracurricular/athletic activity:

We agree, here and forever, to the maximum extent permitted by law, for ourselves, our family, our heirs, personal representative(s), and/or assigns, to defend, hold harmless, indemnify and release, the Walnut Valley Unified School District ("District"), its Board members, administrators, officers, agents, and employees, from and against any and all claims, demands, actions, or causes of action of any sort, present or future, on account of damage to personal property, or personal injury, or illness, or death which may result from student's participation in the extracurricular/athletic activity. This release specifically includes claims based on the negligence of the District and its Board members, administrators, officers, agents, and employees. **We understand that we are releasing claims and giving up substantial rights, including our right**

**to sue, and are doing so voluntarily. No representations, statements, or inducements, oral or written, apart from the foregoing written statement, have been made.**

**PLEASE NOTE:** California Education Code Section 35330 states in part: “All persons making the field trip or excursion shall be deemed to have waived all claims against the district, a charter school, or the State of California for injury, accident, illness, or death occurring during or by reason of the field trip or excursion. All adults taking out-of-state field trips or excursions and all parents or guardians of pupils taking out-of-state field trips or excursions shall sign a statement waiving all claims.” **On behalf of student and myself, we understand that this extracurricular/athletic activity may involve excursions or field trips as defined by Section 35330 of the California Education Code, and we agree to waive all such claims.**

**WE HAVE READ, UNDERSTAND, AND AGREE TO ALL TERMS AND CONDITIONS OF THIS DOCUMENT**

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Student/Participant

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Date

**WALNUT VALLEY UNIFIED SCHOOL DISTRICT  
PARENT'S OR GUARDIAN'S PERMISSION FOR STUDENT PARTICIPATION IN  
EXTRACURRICULAR/ATHLETIC ACTIVITY  
MEDICAL TREATMENT AUTHORIZATION**

To the Principal of: \_\_\_\_\_ (School)

\_\_\_\_\_ has my permission to participate in  
(Student Name: please print)

\_\_\_\_\_ during the \_\_\_\_\_.  
(Extracurricular/Athletic Activity) (School Year/Semester/Quarter)

Supervising Teacher / Coach (please print): \_\_\_\_\_

I understand that the extracurricular/athletic activity, by its very nature, includes certain risks and could cause minor injury, major injury, and serious injury to student, including permanent disability and death. In the event of illness or injury to student, I do hereby consent to whatever x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, emergency transportation, and hospital care of student considered necessary in the best judgment of the attending physician, surgeon, or dentist and performed under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services.

\_\_\_\_\_ Student has no special health needs the staff should be aware of, and no medication is required during this class/activity.

\_\_\_\_\_ Student has a special need, and instructions are attached. Number of attached pages: \_\_\_\_\_.

\_\_\_\_\_ Other: \_\_\_\_\_

Medical Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
(e.g., Blue Cross)

In the event of an **emergency**, please contact:

_____	_____	Work: ( ) _____
(Name)	(Relationship)	Home: ( ) _____
		Cell: ( ) _____

_____	_____	_____
Signature of Parent/Guardian	Please Print Name	Date

_____	_____	_____
Signature of Student	Please Print Name	Date