

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ BOY GIRL GRADE \_\_\_\_\_  
 (circle one)  
 SPORT(S) \_\_\_\_\_ FULLERTON UNION HIGH SCHOOL DISTRICT HEALTH SERVICE OFFICE  
 18-19  
 RETURN TO: B.P.H.S. L.H.H.S. L.V.H.S. S.H.H.S. S.O.H.S. T.R.H.S.  
 F.U.H.S.

**TO THE PRIVATE PHYSICIAN:**

Kindly complete this brief medical examination form and indicate assignment in physical education or athletics for this student. **This form must have the date of the physical, the examining physician's signature, address and phone number and yes or no checked to indicate the student is or is not healthy enough for all physical activity.** The inventory on the back should be completed and signed by the parents prior to the student's visit to the physician, and if filled in accurately, should adequately cover the student's medical history. Completed forms are to be returned to the school by the student along with all other forms required for athletic clearance.

DATE OF EXAMINATION:	IMMUNIZATION	COMPLETE WITH DATES	COMMENTS: <b>Please place Doctor's Stamp Here</b> ↓
Student's Age _____ Height _____ Weight _____ Vision (Shellen) R 20/____ L 20/____ Glasses: YES NO Audiometer Test: _____ Type _____ Results: R _____ L _____	Tetanus _____ Polio Vaccine _____ Measles: _____ Rubeola _____ Rubella _____ Mumps _____	_____ _____ _____ _____ _____	Doctor Information Date: _____ Athletics: YES NO Signature _____ Address _____ City _____ Phone _____
Eyes _____ Ears _____ Nose _____ Throat _____ Tonsils _____ Oral Hygiene _____ Condition of Teeth _____ Bridgework _____	Normal Abnormal Dentures _____ General Appearance _____ Skin _____ Glands _____ Lungs _____ Heart Sound _____ Blood Pressure _____ Pulse _____	Normal Abnormal	Doctor Information

## Pre-participation Physical Evaluation

### History

Date \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Grade \_\_\_\_\_ Sport(s) \_\_\_\_\_

Personal Physician \_\_\_\_\_

Address

Physician Phone

### Explain "Yes" answers below:

Yes No

- |                                                                                                                                                                                                |                          |                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Have you ever been hospitalized?.....                                                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery?.....                                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you presently taking any medications or pills?.....                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have any allergies (medicine, bees or other stinging insects)?.....                                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever passed out during or after exercise?.....                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy during or after exercise?.....                                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had chest pain during or after exercise?.....                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you tire more quickly than your friends during exercise?.....                                                                                                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had high blood pressure?.....                                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been told you have a heart murmur?.....                                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had racing of your heart or skipped heartbeats?.....                                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Has anyone in your family died of heart problems or a sudden death before age 50?.....                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any skin problems (itching, rashes, acne)?.....                                                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had a head injury?.....                                                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been knocked out or unconscious?.....                                                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a seizure?.....                                                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had heat or muscle cramps?.....                                                                                                                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy or passed out in the heat?.....                                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have trouble breathing or do you cough during or after activity?.....                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you use any special equipment (pads, braces, neck rolls, mouth guards, etc.)?.....                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever had any problems with your eyes or vision?.....                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear glasses or contacts or protective eye wear?.....                                                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated Swelling or other injuries of any bones or joints?.....                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Thigh <input type="checkbox"/> Neck <input type="checkbox"/> Elbow <input type="checkbox"/> Knee      | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Chest <input type="checkbox"/> Forearm <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle |                          |                          |
| <input type="checkbox"/> Hip <input type="checkbox"/> Hand <input type="checkbox"/> Foot                                                                                                       |                          |                          |
| 12. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?.....                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you had a medical problem or injury since your last evaluation?.....                                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |

### Explain "Yes" answers:

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

Date \_\_\_\_\_ Signature of Athlete \_\_\_\_\_

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

Parent Printed Name \_\_\_\_\_

