Doctor Form

HEMET UNIFIED SCHOOL DISTRICT

ATHLETIC PHYSICAL SCREENING FORM

TO BE COMPLETED BY PHYSICIAN i.e., MD, DO, PA, NP, RNP, DC

Name________________________ Social Security No.________________ Sport____________

Height______ Weight______ Blood Pressure__________ Pulse__________ Temp__________

Vision; R20/_______ L20/_______ Corrective Lenses:Yes__ No__ Corrected Vision R20/____ L20/____

Immunization Dates: Measles or MR__________ TD or Tetanus__________

Physical Exam (Please elaborate on any abnormality in the history)

	Normal	Abnormal	Describe Abnormality in Detail
Head, Face and Scalp			
Mouth, Nose & Throat			
Tonsils in ( ) out ( )			
Ears			
Eyes			
Neck (thyroid)			
Lymph nodes			
Lungs and Chest			
Breasts			
Heart			
Vascular system			
Abdomen (include hernias)			
Genitalia			
Musculoskeletal (strength and range of motion)			
Neck			
Shoulders			
Elbows			
Hands/Wrists			
Spine			
Knees			
Ankles			
Feet			
Skin			
Neurological			

Assessment:

Recommendations/preventative measures:

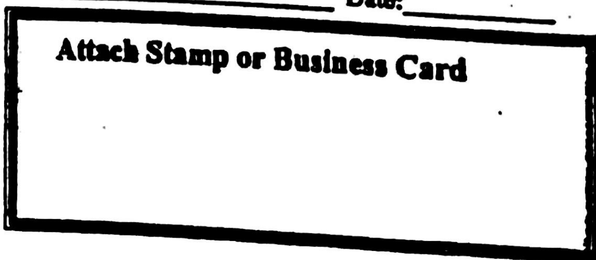
CLEARANCE (CIRCLE APPROPRIATE CATEGORY)

1. No Limitations to contact/collision
2. Limited contact/impact
3. No – contact
   a. strenuous b. non-strenuous
4. Clearance deferred until seen by team physician or specialist

Physician's Name____________________

Physician's Signature____________________

Phone:________________ Date:__________


Attach Stamp or Business Card

Scanned by CamScanner

Parent Form

Sport________________
Male or Female________

PHYSICAL SCREENING

This screening physical exam is for the purpose of participation in interscholastic athletics in the Hemet Unified School District. This physical exam is a confidential document. Please answer medical history questions accurately.

Name______________________________ Birthdate__________ Social Security______________

Address______________________________ Home Phone______________

Emergency Phone______________

City State Zip

Explain ALL "YES" answers below.

#	Question	Yes	No
1.	Have you had a medical illness or injury since your last sports physical?		
2.	Do you have an ongoing illness?		
3.	Have you ever been hospitalized overnight?		
4.	Have you ever had surgery?		
5.	Are you currently taking prescription or over the counter medications or using an inhaler?		
6.	Have you ever taken supplements or vitamins to help you gain or lose weight or improve your performance?		
7.	Do you have any allergies? If yes, to what?		
8.	Have you ever had a rash or hives develop during or after exercise?		
9.	Have you ever passed out during exercise?		
10.	Have you ever been dizzy during or after exercise?		
11.	Have you ever had chest pain during or after exercise?		
12.	Have you ever had racing of your heart or skipped beats?		
13.	Have you ever had high blood pressure or high cholesterol?		
14.	Have you ever been told you have a heart murmur?		
15.	Has any family member died of heart problems or of sudden death before the age of 50?		
16.	Have you had a severe viral infection (for example mononucleosis or myocarditis) within the last month?		
17.	Has a physician ever denied or restricted your participation in sports for any heart problems?		
18.	Do you have any current skin problems?		
19.	Have you ever had a head injury or concussion? If yes, how many and date.		
20.	Have you ever had a seizure?		
21.	Do you have frequent or severe headaches?		
22.	Have you ever had numbness or tingling in your arms, hands, legs or feet?		
23.	Have you ever had a burner or stinger, or pinched nerve?		
24.	Have you ever become ill from exercising in the heat?		

#	Question	Yes	No
25.	Do you cough, wheeze, or have trouble breathing during or after activity?		
26.	Do you have asthma?		
27.	Do you have seasonal allergies that require treatment?		
28.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position?		
29.	Have you had any problems with your eyes or vision?		
30.	Have you ever had a sprain, strain, or swelling after injury?		
31.	Have you broken or fractured any bones or dislocated any joints?		
32.	Have you have any other problems with pain or swelling in muscles, tendons, bones, or joints?		
***	If YES #30-32, circle appropriate location and explain below. Head, Neck, Back, Chest, Shoulder, Upper Arm, Elbow, Forearm, Wrist, Hand, Finger, Hip, Thigh, Knee, Shin/Calf, Ankle, Foot		
33.	Do you want to weigh more or less than you do now?		
34.	Do you loose weight regularly to meet weight requirements for your sport?		
35.	Record the dates or your most recent immunizations for: Tetanus: Measles: Hepatitis B: Chickenpox:		

Explain ALL "YES" answers here: Include date where applicable

#	FEMALE ATHLETES ONLY		
36.	When was your first menstrual period?		
37.	When was your most recent menstrual period?		
38.	How much time do you usually have from the start of one period to the start of another?		
39.	How many periods have you had in the last year?		
40.	What was the longest time between periods in the last year?		
41.	Are you currently pregnant?		

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct, and grant permission for my son/daughter to participate in the screening.

Signature of Parent/Guardian______________________________ Date______________