PLACENTIA-YORBA LINDA UNIFIED SCHOOL DISTRICT
SPORTS PRE-PARTICIPATION PHYSICAL

Name_____ Age_____ [ ] Male [ ] Female
Date of Birth_____ Grade_____ School_____ School Year [ ] 20___ [ ] 20___ [ ] 20___
Check sport(s) of participation:
[ ]Band [ ]Baseball [ ]Basketball [ ]Cheer [ ]Color Guard [ ]Cross-country [ ]Dance [ ]Diving [ ]Football [ ]Golf [ ]Lacrosse [ ]Song
[ ]Tennis [ ]Soccer [ ]Softball [ ]Track/Field [ ]Swim [ ]Volleyball [ ]Water Polo [ ]Wrestling [ ]Other_____

Parent - Please answer questions 1 – 21

Has the student/athlete ever:	**YES**	**NO**
1. Been hospitalized overnight? Diagnosis		
2. Had any chronic illness? [ ] asthma [ ] diabetes [ ] frequent headaches [ ] bleeding disorder [ ] Other		
3. Recently taken medication including over-the-counter meds or inhalers? Medication:		
4. Had any allergies (medication, bee stings, etc) Allergy:		
5. Become dizzy or passed out during exercise?		
6. Developed chest pain, shortness of breath or wheezing?		
7. Become tired more quickly than peers during exercise?		
8. Been told that he/she has a heart murmur or heart disease?		
9. Skipped heart beats?		
10. Had anyone in the family develop heart disease or die from heart problems under age 40?		
11. Had a significant head injury or concussion?		
12. Passed out or had a seizure?		
13. Had more than one episode of burner/stinger (pain from neck into arm)?		
14. Had heat cramps or heat exhaustion?		
15. Had a broken/fractured, sprained, or dislocated body part? List body part(s) and date(s) of injury.		
16. Is the student/athlete missing an organ or limb? List body part(s) and date(s) of loss.		
17. Does student/athlete use special equipment? [ ] Pads [ ] Braces [ ] Orthotics [ ] Prostheses [ ] Other		
18. Does student/athlete have to gain or lose weight to meet the requirements of his/her sport(s)?		
19. Does student/athlete eat a healthy well balanced diet?		
For females: 20. Are menses (periods): [ ] regular/monthly [ ] irregular [ ] absent		
21. Last tetanus immunization:		

I hereby authorize the use and/or disclosure of my student/athlete's individual health information for the purpose of medical clearance for participation in the district's sports program. I understand that this authorization is voluntary.

Student's Signature_____ Date _____

Parent's Signature_____ Date _____

PHYSICAL EXAMINATION BY PHYSICIAN

Height_____ Weight_____ BP_____ Pulse_____ Body Habitus_____
Visual Acuity: Right eye 20/_____ Left eye 20/_____ Both eyes 20/_____

Legend: / = within normal limits + = see comments x = omitted

General	/	+	x	General	/	+	x	Orthopedic	/	+	x	Orthopedic	/	+	x
Head				**Heart**				**Cervical Spine/back**				**Knees**			
Eyes				**Abdomen**				**Arms/elbows/wrists/hands**				**Ankles/feet**			
Ears/nose/throat				**Genitalia/hernia**				**Hips**				**Flexibility**			
Neck				**Neurological**											
Comments:															

Discussion Items	Check
Stretching emphasized	☐ yes ☐ no
Discussed fitness/ideal weight	☐ yes ☐ no
Discussed treatment of injuries	☐ yes ☐ no
Discussed prevention of sun/heat-related problems	☐ yes ☐ no
Discussed testicular cancer exams	☐ yes ☐ no

MEDICAL CLEARANCE (as appropriate for age and development):	Check
Full contact collision level	☐ yes ☐ no
Clearance deferred or no participation at this time because	☐ yes ☐ no

MD/DO/FNP:	**State License Number:**	**Phone:**
Address (Doctor's Stamp Required):		**Date:**

Revised 05/08