

VISALIA UNIFIED SCHOOL DISTRICT

HISTORY: This side to be completed and signed by parent and student
Opposite side to be completed, signed and stamped by MD,DO,NP or PA
Completed form to be turned into Health Office at least 48 hrs prior to tryouts

Name: _____	Sex: _____	Age: _____	Date of Birth: _____
Grade: _____	ID# _____	Sport(s): _____	
Address: _____		Phone: (_____) _____	
Personal Physician/Provider: _____			

Explain "Yes" answers below.

	Yes	No		Yes	No
1. Do you think you are in good health?	<input type="checkbox"/>	<input type="checkbox"/>	23. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an ongoing medical condition? (ex: diabetes or asthma)	<input type="checkbox"/>	<input type="checkbox"/>	24. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills?	<input type="checkbox"/>	<input type="checkbox"/>	25. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	26. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has a physician ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	27. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29. Have you had infectious mononucleosis within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
9. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	31. Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has a doctor ever told you that you have (circle all that apply) High Blood Pressure A Heart Murmur High Cholesterol A Heart Infection	<input type="checkbox"/>	<input type="checkbox"/>	32. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has a doctor ever ordered a test for your heart? Example: ECG, echocardiogram	<input type="checkbox"/>	<input type="checkbox"/>	33. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
12. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	34. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
13. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	35. Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
14. Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	36. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
15. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	37. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	38. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you ever had an injury, like a sprain, muscle, ligament tear, or tendinitis that caused you to miss a practice or game? If yes, circle affected area below:	<input type="checkbox"/>	<input type="checkbox"/>	40. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	41. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitations, physical therapy, a brace, a cast or crutches? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	42. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
Head Neck Shoulder Upper Arm Elbow Chest Hand/Fingers Forearm			43. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Ankle Foot/Toes Upper Back Lower Back Hip Thigh Knee Calf/Shin			44. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	45. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>	46. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
			47. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
FEMALES ONLY					
			48. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
			49. How old were you when you had your first menstrual period?	_____	
			50. How many periods have you had in the last 12 months?	_____	

Explain "Yes" Answers Here: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.	
Signature of athlete _____	Date: _____
Signature of parent/guardian _____	Date: _____

PHYSICAL EXAMINATION FOR INTERSCHOLASTIC ATHLETICS

NAME _____ **Student ID#** _____ **Date of Birth** _____

Height _____ Weight _____ BMI (optional) _____ Pulse _____ BP _____ / _____ (____ / ____ / ____)

Vision: R 20/ _____ L 20/ _____ Corrected: Yes No Pupils: Equal _____ Unequal _____

EMERGENCY INFORMATION

Allergies/Other: _____

	Normal	Abnormal Findings	Initials*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

Date of last Tdap booster: _____ Varicella Documentation: _____

CLEARANCE

- Cleared without restriction, may compete in : All Sports Contact Sports Non-Contact Sports
- Cleared, with recommendations for further evaluation or treatment for: _____
- Not cleared for: All Sports Certain Sports: _____

Name of Physician/Provider: (print/type/stamp) _____ (MD, DO, NP or PA)

Address: _____ Phone: _____

Signature of Physician: _____

Date of Exam: _____

MEDICAL OFFICE STAMP (Required)

THIS EXAM MUST HAVE A STAMP, SIGNATURE, AND DATE OF EXAM