

Fremont Union High School District

Physical Exam Form - Part 1

Student/Athlete's Health History (Required)

School:	School: School Year:			Sports/Activities Trying Out for:				
Last Name:			F	First Name: M.I.:		Male		
Grade:	Home Ph:			Date of Birth: Age:		Female		
Home Address:				City: Zip:				
Name of Family Doctor or Medical Clinic/Hospital:								
Street Address of Doctor or Medical Clinic/Hospital:								
City:	Zip:			Doctor's Office Phone Number:				
STUDENT'S HEALTH HISTORY : To be completed by the Parent/Guardian and reviewed by the doctor at time of the student's Physical Exam. Parents, please check ($$) "Yes" or "No" to the questions below about your child's health history.								
Date of student's last Diphtheria/Tetanus shot? (month/day/year)								
Has the student	t had any:	Yes	No	Is there any history of:	Yes	No		
1. Chronic or rec	current illness?			14. Injuries requiring Doctor's treaments?				
2. Illness lasting over 1 week?				15. Neck or back injury?				
3. Hospitalization?				16. Knee injury?				
4. Surgery other than removal of tonsils?				17. Shoulder or elbow injury?				
5. Missing organs (eye, kidney, testicle)?				18. Ankle injury?				
6. Problems with heart or shortness of breath during exercise?				19. Other serious joint injury?				
7. Dizziness or fainting with exercise?				20. Broken bones or fractures?				
9 Existing had	fainting with exercise?			21. Other serious injury?				
o. rainting, bad	fainting with exercise? headaches, or convulsions?			21. Other serious injury?				
	e			21. Other serious injury? Further History:				

Parent's/Guardian's	& Student's	Acknowledgement
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accident?

less than 35 years of age?

I have reviewed and agree with the information presented on this form. I also understand that the Physical Examination is primarily for sports participation screening and is not intended to replace the routine health care visits as recommended by the student's personal doctor. I do not know of any reason why the above-named student should not participate and represent his/her school in supervised athletic activities.

Signature of Parent/Guardian:

Does this student:

below.

11. Wear eyeglasses or contact lenses?

12. Wear dental bridges, braces, or plates?

13. Take any medications? If so, please list them

Use the space below to explain any questions above that you answered "yes" to:

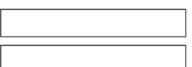
Signature of Student/Athlete:

Date (mo/day/year):

23. Has any family member died suddenly at less

24. Has any family member had a heart attack at

than 40 years of age of causes other than an



Medications your son/daughter is currently taking:

Date (mo/day/year):

Fremont Union High School District

Physical Exam Form - Part 2 Physical Examination Form (Required) A medical doctor (an MD, not a chiropractor) must administer this Physical Exam & sign/date below.

Parents - Please complete the top line for the doctor and please print neatly. All other areas will be completed by the doctor.										
Last Name:	First N	ame: M.I.: Date of Birth: Sch	hool:							
Height: % Body Fat (optional) Pulse: BP: (,)										
Vision: R - 20/ L - 20/	Corrected	d: Y N Pupils: Equal Unequal								
Follow-up Questions on More Se	nsitive Issues - Qu	estions asked by the doctor	Yes No							
1. Do you feel safe?										
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?										
3. Do you feel stressed out or under a lot of pressure?										
4. Have you ever tried cigarette sn	noking, even 1 or 2	2 puffs?								
5. Do you currently smoke?										
6. During the past 30 days, have y										
7. During the past 30 days, have y										
8. Have you ever taken steroid pill		* *								
	ments to help you	gain or lose weight or improve your performance?								
Does this student:										
10. Wear eyeglasses or contact len										
11. Wear dental bridges, braces, or										
12. Take any medications? If so, j	please list them bel	OW.								
Dr.'s Notes:										
DOCTOR'S EXAMINATION	NORMAL	ABNORMAL FINDINGS (Doctor, please list & describe any abnorm	nalities)							
Appearance										
Eyes/ears/nose/throat										
Hearing										
Lymph Nodes										
Heart										
Mummurs										
Pulses										
Lungs										
Abdomen	└──									
Genitourinary (males only)	↓									
Skin	<u> </u>									
MUSCULOSKELETAL	L									
Neck	↓									
Back	↓									
Shoulder/arm	<u>↓ </u>									
Elbow/forearm Wrist/hand/fingers	<u>↓ </u>									
Hips/thigh	<u> </u>									
Knee										
	<u> </u>									
Leg/ankle	┼───┼──									
Foot/toes Multiple-examiner set-up only. **Having a third party pr		ranita universe aramination								
			checks one)							
Exceptions or limitations (if any):										
Doctor's Printed		Doctor's Signature: Date:								
Name & Address:										
(Stamp is okay)		M.D.? Yes No Doctor's I.D. #:								