## CAPISTRANO UNIFIED SCHOOL DISTRICT

SPORTS: (Please check all that apply) Physical Clearance Form Softball o Boys Tennis o Surfing o Girls Water Polo o Lacrosse Cross Country Girls Tennis o Boys Golf o Football Girls Volleyball Basketball Wrestling o Track Swimming o Girls Golf o Boys Water Polo o Soccer Baseball Boys Volleyball Grade in 2025-2026 Male Female Date of Birth / / Name \_\_\_City & Zip Code\_\_\_\_\_\_Phone\_\_\_\_ \_\_\_\_Cell phone \_\_\_ \_\_\_\_Work phone\_\_\_ Father/Guardian\_ Work phone\_\_\_\_ Cell phone\_\_\_ Mother/Guardian Phone\_\_\_\_\_Insurance\_\_\_\_ Emergency Contact \_\_\_\_ \*\*\*I hereby give my consent for the above named student (son/daughter/ward) to compete in sports and to go with a representative of the school on any trips. In case of injury, you are authorized to have him/her treated. \*SIGNATURE OF PARENT/GUARDIAN\* HEALTH HISTORY: TO BE COMPLETED BY PARENT BEFORE DOCTOR EXAM Any past or present: <u>Yes</u> No Yes No Problems with vision Surgeries Dental problems Eyeglasses Contacts Braces Problems with hearing False teeth Hearing aid. Painful joints Blacking out or fainting Broken bones Body part,date\_ Unconsciousness Convulsions. Knee or ankle problems seizures Require support/brace Heart problems Need for medication Name Menstruation problems Rheumatic fever Hernias Bleeding disorders Asthma **Blood sugar problems** OTHER HEALTH ASPECTS THE DOCTOR Hypoglycemia AND SCHOOL SHOULD BE AWARE OF: Diabetes Allergies- type Bee or insect stings Hospitalizations Any history of chest pain with exercise? Any history of "racing" heart or skipped beats? Do you experience passing out, near passing out or unexpected tiredness during exercise? Any family history of sudden cardiac death in afamily member under the age of 50? Any family history of Marfan's syndrome Or prolonged QT syndrome? Any history of temporary numbness or paralysis of both arms and/or legs following head/spine trauma? Any history of recent severe viral illness, infectious mononucleosis, or hepatitis? Any history of the following: absence of one kidney? males: absence of one testicle? Any history of blindness in one eye? Any current active skin infection? (Physician/Physician's asst/Nurse Practitioner) \_\_\_WEIGHT \_\_\_ PHYSICAL EXAM: HEIGHT **PULSE:** RESTING \_AFTER ACTIVITY\_\_ B.P. **EYES** THROAT ABDOMEN ORTHOPEDIC **EARS** LYMPH GLANDS HERNIA SKIN TEETH THYROID POSTURE OTHER BRACES HEART MUSCLE TONE NOSE LUNGS REFLEXES Special doctor recommendations or restrictions I have examined the above student and do recommend that he/she is physically fit for full participation in sports. (Must be signed by a PHYSICIAN, PHYSICIAN'S ASSISTANT or NURSE PRACTITIONER) Name of physician M.D/DO/PA/NP Date\_\_\_\_\_ \*\*Physician's Office Stamp\*\* \_\_\_\_\_Phone\_\_\_\_\_