

VISTA UNIFIED SCHOOL DISTRICT
Athletic Screening History & Physical Exam

Please indicate:

Mission Vista HS

Rancho Buena Vista HS

Vista HS

Student Name:	Student ID #:
Address:	Date of Birth:
City/Zip:	Graduating Year:
Home Phone:	Parent Name / Cell # :
Emergency Contact / Phone:	Parent Name / Cell # :

EXPLANATION OF SCREENING PHYSICAL

I realize that the medial evaluations performed are only screens in order to evaluate general health, to disclose existing problems, and to determine my son/daughter's dynamic ability to participate in a given sport so that obvious conditions which might be damaged or aggravated by competitive sports can be found, evaluated and treated so as to prevent further injury. This examination does not guarantee against injury.

Parents Initials _____

AWARENESS OF RISK

STUDENT AND PARENT - I am aware that playing/practicing sports can be a dangerous activity involving many risks of injury. I understand that the risks of participation include, but are not limited to, death, serious neck and spinal cord injuries that may result in complete or partial paralysis, brain damage, serious internal injury to virtually any internal organs, bones, joints, muscles, tendons, or any other aspect of the skeletal system, and serious injury or impairment to other aspects of my body, general health and well being. I understand that the risks of participant may result not only in serious injury, but in impairment of my future ability to earn a living, to engage in other business, social and recreational activities, and generally to enjoy a good life. Because of the dangers of participant in sports, I recognize the importance of following coaches' instructions regarding playing techniques, training, equipment and other team rules, etc. both in competition and practice and agree to obey such instructions.

Parents Initials _____

PERMISSION FOR TREATMENT

I hereby grant permission to the Athletic Trainer, Team Physicians and those professional personnel designated by Vista Unified School District to treat my son/daughter in the event of an injury. In the event of a serious injury, if I am unable to give my consent at that time, this consent is to include any and all emergency procedures deemed necessary by the attending emergency personnel. I also understand that in the event of injury, every reasonable attempt will be made to contact me prior to securing medial treatment beyond basic first-aid.

Parents Initials _____

PROOF OF INSURANCE

In compliance with California Education Code 32221, I certify that there s in effect at this time insurance coverage for medial expenses resulting from bodily injury of at least \$5,000 for my son/daughter, and that this coverage will remain in effect throughout the time that he/she participates in sports. I also give my permission for the above named student to participate in sports, including regularly scheduled trips by supervision school transportation.

Parents Initials _____ Insurance Carrier _____ Policy # _____

I have read the above statement, EXPLANATION OF SCREENING PHYSICAL, AWARNESS OF RISKS, and PERMISSION FOR TREATMENT, and understand them fully and agree/consent to their contents.

Parent Signature: _____ Date: _____

Student Signature: _____ Date: _____

Student Name: _____

Health History - Please answer the following in the check box provided. Explain "yes" answers in the box below.

1. Have you ever been hospitalized (overnight)? Yes No
2. Have you ever had surgery? Yes No
3. Are you currently taking medication? Yes No
4. Do you have any allergies (medicines, pollen, bees)? Yes No
5. Have you ever passed out during exercise? (not from heat) Yes No
6. Have you ever been dizzy during exercise? (not from heat) Yes No
7. Have you ever had chest pain? Yes No
8. Do you tire more quickly than your friends during exercise? Yes No
9. Have you ever had high blood pressure? Yes No
10. Have you ever been told you had a heart murmur? Yes No
11. Have you ever had racing of your heart or skipped beats? Yes No
12. Has anyone in your family died of heart problems or a sudden death before age 40? Yes No
13. Does anyone in your family have Marfan's Syndrome? Yes No
14. Do you have any skin problems (itching, rashes, breaking out)? Yes No
15. Have you ever had a head injury? Yes No
Have you ever been knocked out? Yes No
Have you ever had a seizure? Yes No
Have you ever had a burner/stinger? (pain from neck to arm) Yes No
16. Have you ever had heat cramps? Yes No
Have you ever been dizzy or passed out in the heat? Yes No
17. Do you use special pads or orthotic braces? Yes No
18. Have you ever injured (broken/fractured, sprained, dislocated)?
 Hand / fingers Shoulder Hip Shin / calf Wrist / forearm Neck Thigh
 Ankle Elbow Chest/ribs Knee Foot / toes Upper arm Back
 Stress fractures?
19. Have you ever had?
 Mononucleosis Diabetes Hepatitis Headaches (frequent) Eye/ear injuries
 Tuberculosis Measles Hernia(s) Asthma Ulcers
 Sickle cell trait/disease
20. When was your last tetanus shot? _____
21. About your weight: Do you think you are . . . just Right? too Heavy? too Thin / Light?
For females: Are your periods Regular/monthly? Irregular / skip months?
When was your first period and how old were you? _____ When was your last period? _____

Please ask the doctor to address any questions that you may have. [All discussions are kept confidential.]

Please Explain and "YES" answers here:

Student Name: _____

Circle the sport(s) you will be participating in:

Baseball Basketball Cheerleading Cross Country Field Hockey
Football Golf Soccer Softball Swimming
Track/Field Tennis Volleyball Water Polo Wrestling

Physical Examination

(To be completed by Medical Personnel)

Height _____

Blood Pressure _____
(sitting, left arm)

Vision (optional)
Left eye 20 / _____
Right eye 20 / _____
Both eyes 20 / _____

Weight _____

Pulse _____

with / without glasses

1. Skin	
2. Head	
3. Eyes (PERLA, EOMI, Fundi)	
4. Ears nose, throat	
5. Neck	
6. Lymphatic	
7. Respiratory	
8. Cardiovascular Heart (murmurs)?	
9. Abdomen	
10. Extremities	
11. Neurological Reflexes	
12. Orthopedic	
Cervical spine/back	
Arms/elbows/wrist/hands	
Hips	
Knees	
Ankles/feet	

√ = within normal limits

+ = see comments

X= omitted

Comments / Recommendations:

Student Name: _____

MEDICAL CLEARANCE

(As appropriate for age and development)

- Full contact/collision level (full, unrestricted participation)
- Limited contact / impact
- Non contact: strenuous
- Non contact: non-strenuous
- Clearance deferred or no participation at this time because:
 - Needs clearance by specialist
 - Orthopedist Cardiologist
 - Other : _____
 - Needs to complete rehabilitation for current condition(s) prior to participation

Physician's Statement:

(Student's name) _____ was examined by me on _____(date) and found physically fit to engage in high school athletics. Results are to encourage, but in no way guarantee, the fitness and safety of this athlete.

Practitioner signature: _____ Date: _____

M.D. / D.O. / N.P. / P.A. / D.C.

Do not sign without student's name filled in

Physician's Office Stamp HERE (REQUIRED)