

GLENDALE UNIFIED SCHOOL DISTRICT

PRE-PARTICIPATION PHYSICAL EVALUATION

HISTORY

Date Of Exam _____

Name _____ Sex _____ Age _____ Date of Birth _____

Grade _____ School _____ Sport(s)/Activity _____

Address _____ Phone _____

Personal Physician _____

In case of emergency, contact: Name _____ Relationship _____

Home phone # _____ Cell phone # _____ Work phone# _____

**Explain all "Yes" answers below, circle questions you don't know the answer to.*

Yes No	Yes No
<p>____ 1. Have you had a medical illness or injury since your last checkup or sports physical? Do you have an ongoing or chronic illness? ____ 2. Have you ever been hospitalized overnight? Have you ever had surgery? ____ 3. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler? Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? ____ 4. Do you have any allergies (examples: pollen, medicine, food, or stinging insects)? Have you ever had a rash or hives develop during or after exercise? ____ 5. Have you ever passed out during or after exercise? Have you ever been dizzy during or after exercise? Have you ever had chest pain during or after exercise? Do you get tired more quickly than your friends during exercise? Have you ever had racing of your heart or skipped heartbeats? Have you had high blood pressure or high cholesterol? Have you ever been told you have a heart murmur? Has any family member or relative died of heart problems or of sudden death before age 50? Have you had severe viral infection (examples: myocarditis or mononucleosis) within the last month? Has a physician ever denied or restricted our participation in sports for any heart problems? ____ 6. Do you have any current skin problems (examples: itching, rashes, acne, warts, fungus, or blisters)? ____ 7. Have you ever had a head injury or concussion? Have you ever been knocked out, become unconscious, or lost your memory? Have you ever had a seizure? Do you have frequent or severe headaches? Have you ever had numbness or tingling in your arms, hands, legs, or feet? Have you ever had a stinger, burner, or pinched nerve?</p>	<p>____ 8. Have you ever become ill from exercising in the heat? ____ 9. Do you cough, wheeze, or have trouble breathing during or after activity? Do you have asthma? Do you have seasonal allergies that require medical treatment? ____ 10. Do you use any special protective or corrective equipment or devices that aren't usually used for your activity or position (examples: knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? ____ 11. Have you had any problems with your eyes or vision? Do you wear glasses, contacts, or protective eyewear? ____ 12. Have you ever had a sprain, strain, or swelling after injury? Have you broken or fractured any bones or dislocated any joints? Have you had any other problems with pain or swelling in muscles, tendon, bones, or joints? <i>If "Yes", check all appropriate spaces and * explain below:</i> ____ Head ____ Neck ____ Back ____ Chest ____ Shoulder ____ Upper Arm ____ Elbow ____ Forearm ____ Wrist ____ Hand ____ Finger ____ Hip ____ Thigh ____ Knee ____ Shin/Calf ____ Ankle ____ Foot ____ 13. Do you want to weigh more or less than you do now? Do you lose weight regularly to meet weight requirements for your activity? ____ 14. Do you feel "stressed out"? 15. Record the dates of your most recent immunizations (shots) for: Tetanus _____ Measles _____ Hepatitis B _____ Chickenpox _____ Females Only: 16. When was your first menstrual period? _____ When was your most recent menstrual period? _____ How much time do you usually have from the start of one period to the start of another? _____ How many periods have you had in the last year? _____ *Explain all "Yes" answers here: _____</p>

I hereby certify that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Parent/Guardian _____ Date _____ Signature of Student _____ Date _____

I give permission for my son/daughter/ward to be examined by his/her own physician, or a physician associated with Glendale Healthy Kids, Glendale Memorial Hospital & Health Center, Verdugo Hills Hospital, Verdugo Hills Medical Associates, or Family Medicine Center.

Signature of Parent/Guardian _____ Date _____

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PRE-PARTICIPATION PHYSICAL EVALUATION (continued)

PHYSICAL EXAMINATION

Name _____ Date of Birth _____

Height _____ Weight _____ %Body Fat _____
 (optional) _____ Pulse _____ BP _____ / _____ (_____ / _____, _____ / _____)

Vision: R 20/ _____ L 20/ _____ Corrected (check): Y ___ N ___ Pupils: Equal _____ Unequal _____

	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			

*Station-based examination only

CLEARANCE:

_____ **CLEARED**

_____ **CLEARED AFTER COMPLETING EVALUATION/REHABILITATION FOR:**

_____ **NOT CLEARED FOR:** _____

Reason: _____

Recommendation(s): _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____