Mt. Eden Athletic Department

Hayward Unified School District - SPORTS PHYSICAL EXAMINATION FORM

PART 1 (TO BE COMPLETED BY A PARENT OR LEGAL GUARDIAN)

LAST NAME	FIRST NAME	GRADE

BIRTHDATE	FALL SPORT	WINTER SPORT	SPRING SPORT	STUDENT ID NUMBER

HEALTH HISTORY (Must be Completed Prior to the Examination)

	Yes	No	Has this student had any:		Yes	No	Does this student:
1.	□	□	Chronic or recurrent illness?	16.	□	□	Wear eyeglasses or contact lenses?
2.	□	□	Illness lasting over 1 week?	17.	□	□	Wear dental bridges, braces or plates?
3.	□	□	Hospitalizations or Surgery?	18.	□	□	Take any medications? (List below):
4.	□	□	Nervous, psychiatric, or neurologic condition?				
5.	□	□	Loss or nonfunctioning of organs (eye, kidney, liver, testicle) or glands?		Yes	No	Is there any history of:
6.	□	□	Allergies (medicines, insect bites, food)?	19.	□	□	Injuries requiring medical care or treatment?
7.	□	□	Problems with heart or blood pressure?	20.	□	□	Neck or back pain or injury?
8.	□	□	Chest pain or severe shortness of breath with exercise?	21.	□	□	Knee pain or injury?
				22.	□	□	Shoulder or elbow pain or injury?
9.	□	□	Dizziness or fainting with exercise?	23.	□	□	Ankle pain or injury?
10.	□	□	Fainting, bad headaches or convulsions?	24.	□	□	Other joint pain or injury?
11.	□	□	Concussion or loss of consciousness?	25.	□	□	Broken bones (fractures)?
12.	□	□	Heat exhaustion, heatstroke, or other problems with heat?		Yes	No	Further history:
				26.	□	□	Birth defects (corrected or not)?
13.	□	□	Racing heart, skipped, irregular heartbeats, or heart murmur?	27.	□	□	Death of parent or grandparent less than 40 years of age due to medical cause or condition?
14.	□	□	Seizures?	28.	□	□	Parent or grandparent requiring treatment for heart condition less than 50 years of age
15.	□	□	Severe or repeated instances of muscle cramps?				
Date of last known tetanus (lockjaw) shot: _____ Date of last complete physical examination:				29.	□	□	Been seen by a physician on an emergency or urgent basis in the last 12-months?

Explain all "YES" answers here along with any other fact or circumstance that should be disclosed prior to the examination (use reverse of form if needed):

PARENT/GUARDIAN'S AUTHORIZATION: I authorize a physician or duly authorized and supervised physician's assistant or nurse practitioner to perform a Sports Physical Evaluation on the student. The information set forth above is complete and accurate and I know of no reason why the student cannot fully and safely participate in the listed sports. I understand that this is solely a screening examination and that the absence of any health conditions or concerns listed below does not mean that student is free from actual or potential harmful health conditions that may cause the student injury or death while participating in sports. Any question or concern I may have regarding the student's health or safety will be referred to our personal physician or health care provider for review and evaluation.

PRINT NAME OF PARENT OR GUARDIAN	SIGNATURE OF PARENT OR GUARDIAN		
ADDRESS	WORK PHONE	HOME PHONE	DATE

REGULAR PHYSICIAN'S NAME	OFFICE PHONE	

PART 2 (TO BE COMPLETED BY THE EXAMINING PHYSICIAN/PHYSICIAN'S ASSISTANT/NURSE PRACTITIONER)

	NORMAL	ABNORMAL (Describe)	
Eyes/Ears/Nose/Throat			Height:
Skin			Weight:
Heart			Pulse: After Ex:
Abdomen			BP:
Genital/hernia (males)			***Recommendation:*** □ Unlimited participation □ Limited participation/specific sports, events or activities □ Clearance withheld pending further testing/evaluation □ No athletic participation ***One of the above MUST be checked.***
Musculoskeletal:			
a. Neck/Spine/Shoulders/Back			
b. Arms/Hands/Fingers			
c. Hips/Thighs/Knees/Legs			
d. Feet/Ankles			
Neurologic Screening Exam (NSE)			

Comments:

PRINT NAME OF PHYSICIAN (M.D., D.O., P.A, or N.P. only)	PHYSICIAN'S SIGNATURE	DATE