

GARDEN GROVE UNIFIED SCHOOL DISTRICT
Preparticipation Physical Evaluation

PHYSICAL EVALUATION

Name _____		Date of Birth _____		Student ID # _____	
Height _____	Weight _____	% Body Fat (optional) _____	Pulse _____	BP _____/_____(_____/_____, ____/____)	
Vision R 20/____	L 20/____	Corrected: Y N	Pupils: Equal _____	Unequal _____	

NORMAL		ABNORMAL FINDINGS	
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			

CLEARANCE:

- ☐ Cleared for participation in competitive interscholastic athletics at the present time.
- ☐ Cleared for participation in competitive interscholastic athletics after completing evaluation/rehabilitation for:

- ☐ Not cleared for participation in competitive interscholastic athletics.
 Reason: _____

Recommendations: _____

Name of Physician (print or type) _____ **Date** _____

Address _____ **Phone:** _____

Signature of Physician (MD, DO, PA, RN) _____ **Medical License #** _____

Physician's Stamp: _____

GARDEN GROVE UNIFIED SCHOOL DISTRICT
Preparticipation Physical Evaluation

DATE OF PHYSICAL EVALUATION _____ **Student ID#** _____ **Graduating Class of** _____

Name: _____ **Sex:** _____ **Age:** _____ **Date of Birth:** _____

Grade _____ **School:** _____ **Sport(s):** _____

Address: _____ **Phone:** _____

Personal Physician: _____ **Phone:** _____

In case of emergency, contact: **Name** _____ **Relationship** _____

Home Phone _____, **Work Phone** _____, **Cell Phone** _____

Explain "Yes" answers below. Circle yes or no to each question (circle question if you do not know the answer).

- | | | | | | | | | | | | | | | | | | | | |
|---|---|------------------------------------|--------------------------------|------------------------------|-------------------------------|----------------------------------|--------------------------------|-------------------------------|--------------------------------|-------------------------------|--------------------------------|-------------------------------|------------------------------------|-----------------------------------|---------------------------------|--------------------------------|------------------------------------|--|-------------------------------|
| <p>1. Have you had a medical illness or injury since your last check up or sports physical? Yes No
Do you have an ongoing or chronic illness? Yes No</p> <p>2. Have you ever been hospitalized overnight? Yes No
Have you ever had surgery? Yes No</p> <p>3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? Yes No
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? Yes No</p> <p>4. Do you have any allergies (i.e., to pollen, medicine, food, or stinging insects)? Yes No
Have you ever had a rash or hives develop during or after exercise? Yes No</p> <p>5. Have you ever passed out during or after exercise? Yes No
Have you ever been dizzy during or after exercise? Yes No
Have you ever had chest pain during or after exercise? Yes No
Do you get tired more quickly than your friends do during exercise? Yes No
Have you ever had racing of your heart or skipped heartbeats? Yes No
Have you had high blood pressure or high cholesterol? Yes No
Have you ever been told you have a heart murmur? Yes No
Has any family member or relative died of heart problems or of sudden death before age 50? Yes No
Have you had a severe viral infection (i.e., myocarditis, or mononucleosis) within the last month? Yes No
Has a physician ever denied or restricted your participation in sports for any heart problems? Yes No</p> <p>6. Do you have any current skin problems (i.e., itching, rashes, acne, warts, fungus, or blisters)? Yes No</p> <p>7. Have you ever had a head injury or concussion? Yes No
Have you ever been knocked out, become unconscious or lost your memory? Yes No
Have you ever had a seizure? Yes No
Do you have frequent or severe headaches? Yes No
Have you ever had numbness or tingling in your arms, hands, legs or feet? Yes No
Have you ever had a stinger, burner, or pinched nerve? ... Yes No</p> | <p>8. Have you ever become ill from exercising in the heat? Yes No</p> <p>9. Do you cough, wheeze, or have trouble breathing during or after activity? Yes No
Do you have asthma? Yes No
Do you have seasonal allergies that require medical treatment? Yes No</p> <p>10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (i.e., knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? Yes No</p> <p>11. Have you had any problems with your eyes or vision? Yes No
Do you wear glasses, contacts or protective eyewear? Yes No</p> <p>12. Have you ever had a sprain, strain, or swelling after injury? Yes No
Have you broken or fractured any bones or dislocated any joints? Yes No
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? Yes No
<i>If yes, check and explain below:</i></p> <table border="0" style="width: 100%;"><tbody><tr><td>☐ Head</td><td>☐ Elbow</td><td>☐ Hip</td></tr><tr><td>☐ Neck</td><td>☐ Forearm</td><td>☐ Thigh</td></tr><tr><td>☐ Back</td><td>☐ Wrist</td><td>☐ Knee</td></tr><tr><td>☐ Chest</td><td>☐ Hand</td><td>☐ Shin/Calf</td></tr><tr><td>☐ Shoulder</td><td>☐ Finger</td><td>☐ Ankle</td></tr><tr><td>☐ Upper Arm</td><td></td><td>☐ Foot</td></tr></tbody></table> <p>13. Do you lose weight regularly to meet weight requirements for your sport? Yes No</p> <p>14. Do you feel stressed out? Yes No</p> | ☐ Head | ☐ Elbow | ☐ Hip | ☐ Neck | ☐ Forearm | ☐ Thigh | ☐ Back | ☐ Wrist | ☐ Knee | ☐ Chest | ☐ Hand | ☐ Shin/Calf | ☐ Shoulder | ☐ Finger | ☐ Ankle | ☐ Upper Arm | | ☐ Foot |
| ☐ Head | ☐ Elbow | ☐ Hip | | | | | | | | | | | | | | | | | |
| ☐ Neck | ☐ Forearm | ☐ Thigh | | | | | | | | | | | | | | | | | |
| ☐ Back | ☐ Wrist | ☐ Knee | | | | | | | | | | | | | | | | | |
| ☐ Chest | ☐ Hand | ☐ Shin/Calf | | | | | | | | | | | | | | | | | |
| ☐ Shoulder | ☐ Finger | ☐ Ankle | | | | | | | | | | | | | | | | | |
| ☐ Upper Arm | | ☐ Foot | | | | | | | | | | | | | | | | | |

Explain "Yes" answers here: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. I hereby permit the above student to participate in competitive interscholastic sports and to receive the physical evaluation by my personal physician or a district approved medical practitioner.

Signature of student/athlete _____ **Date** _____

Signature of parent/guardian _____ **Date** _____