

**CAPISTRANO UNIFIED SCHOOL DISTRICT PHYSICAL SCREENING FORM**

**SPORTS:** \_\_\_\_\_

**Name** \_\_\_\_\_ **Grade** \_\_\_\_\_ **Male** \_\_\_\_\_ **Female** \_\_\_\_\_ **Date of birth** \_\_\_/\_\_\_/\_\_\_

**Address** \_\_\_\_\_ **City & Zip Code** \_\_\_\_\_ **Home Phone** \_\_\_\_\_

**Name of Father/Guardian** \_\_\_\_\_ **Work phone** \_\_\_\_\_ **Cell phone** \_\_\_\_\_

**Name of Mother/Guardian** \_\_\_\_\_ **Work phone** \_\_\_\_\_ **Cell phone** \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_ **Phone Number** \_\_\_\_\_ **Insurance** \_\_\_\_\_

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** \_\_\_\_\_ **Date** \_\_\_\_\_

**HEALTH HISTORY: TO BE COMPLETED BY PARENT BEFORE DOCTOR EXAM**

<u>Any past or present:</u>	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
<b>Problems with vision</b>	_____	_____	<b>Surgeries</b>	_____	_____
<b>Eyeglasses</b>	_____	_____	<b>Dental problems</b>	_____	_____
<b>Contacts</b>	_____	_____	<b>braces</b>	_____	_____
<b>Problems with hearing</b>	_____	_____	<b>false teeth</b>	_____	_____
<b>Hearing aid</b>	_____	_____	<b>Painful joints</b>	_____	_____
<b>Blacking out or fainting</b>	_____	_____	<b>Broken bones</b>	_____	_____
<b>Unconsciousness</b>	_____	_____	<b>Part, date</b> _____	_____	_____
<b>Convulsions, seizures</b>	_____	_____	<b>Knee or ankle problems</b>	_____	_____
<b>Heart problems</b>	_____	_____	<b>Require support/brace</b>	_____	_____
<b>Rheumatic fever</b>	_____	_____	<b>Need for medication</b>	_____	_____
<b>Bleeding disorders</b>	_____	_____	<b>Name</b> _____	_____	_____
<b>Blood sugar problems</b>	_____	_____	<b>Menstruation problems</b>	_____	_____
<b>Hypoglycemia</b>	_____	_____	<b>Hernias</b>	_____	_____
<b>Diabetes</b>	_____	_____	<b>Asthma</b>	_____	_____
<b>Allergies - type</b> _____	_____	_____	<b>OTHER HEALTH ASPECTS THE DOCTOR</b>	_____	_____
<b>Bee or insect stings</b>	_____	_____	<b>AND SCHOOL SHOULD BE AWARE OF:</b>	_____	_____
<b>Hospitalizations</b>	_____	_____	_____	_____	_____

**PHYSICAL EXAM:**    **DATE** \_\_\_\_\_    **HEIGHT** \_\_\_\_\_    **WEIGHT** \_\_\_\_\_

**PULSE:**            **RESTING** \_\_\_\_\_    **AFTER ACTIVITY** \_\_\_\_\_    **B.P.** \_\_\_\_\_

<b>EYES</b>	_____	<b>LYMPH GLANDS</b>	_____	<b>POSTURE</b>	_____
<b>EARS</b>	_____	<b>THYROID</b>	_____	<b>MUSCLE TONE</b>	_____
<b>NOSE</b>	_____	<b>HEART</b>	_____	<b>REFLEXES</b>	_____
<b>THROAT</b>	_____	<b>LUNGS</b>	_____	<b>ORTHOPEDIC</b>	_____
<b>TEETH</b>	_____	<b>ABDOMEN</b>	_____	<b>SKIN</b>	_____
<b>BRACES</b>	_____	<b>HERNIA</b>	_____	<b>OTHER</b>	_____

I have examined the above student and do recommend that s/he is physically fit for full participation in sports.

**Name of physician** \_\_\_\_\_ **MD or DO**    **Date** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Phone number** \_\_\_\_\_

**Special doctor recommendations or restrictions** \_\_\_\_\_

\*\*Please stamp with office stamp\*\*