PHYSICAL EVALUATION

STUDENT NAME: _____

DATE OF BIRTH: _____ **GRADE:** _____

STUDENT MEDICAL RECORD Only designated staff will have access to the completed form. This form will be stored in a locked file.

ADDRESS _____

NAME OF FATHER _____ **NAME OF MOTHER** _____

MEDICAL HISTORY

Please check all that apply, in the space within the box indicate the year that the illness occurred or write "present" if this is a current diagnosis.

□Asthma	□Allergic Rhinitis	□Cancer	□Chicken Pox
□Diabetes	□Diphtheria	□Ear Infections	□Epilepsy
□Heart Disease	□Measles	□Rheumatic Fever	□Scarlet Fever
□Tuberculosis	□Whooping Cough	□Other: _____	_____

ALLERGIES: (List all that apply) Food _____
Drug _____
Environmental _____

Briefly explain factors such as surgeries, serious accidents or injuries, congenital defects, which may affect the child's school experience.

_____

MEDICATIONS

Have physician fill LSA's Medication Administration Form for each medication listed below that may be needed during school hours and overnight school trips.

_____

IMMUNIZATIONS

An official record of immunizations must accompany this medical record for all students entering school for the first time in the United States (regardless of grade level).

Records considered official are:

State Immunization Record
Health Provider Record – must have signature, stamp, or initials next to each date.
Physician's Record
County Health Department Record
Official Immunization Record from another state
School Immunization Record

PHYSICIAN'S EXAMINATION

To be completed by the family *physician* and kept on file at the school for all children a) 1st grade, b) 7th grade (*this should include the scoliosis examination) c) 9th grade

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____/_____

TB Screening *Date* _____/_____/_____ ***TB Clearance*** □**Yes** □**No** ***If No, a TB test is required***
Signature/Agency _____

TB Skin Test	*Type*	*Date Given*	*Given By*	*Date Read*	*Read By*	*Impression*
	□PPD Mantoux □Other _____					□Positive □Negative

Chest X-Ray *Film Date* _____/_____/_____ *Impression* □Normal □Abnormal

Person is free of communicable tuberculosis □Yes □No
Signature/Agency _____

PHYSICAL EVALUATION

Name _____
Last, First M.I.

PHYSICIAN'S EXAMINATION (CONT.)

MEDICAL	Normal	Abnormal	Not Examined	DESCRIPTION OF ABNORMALITIES
Skin				
Eyes, Vision, Glasses				
Ears, Hearing				
Nose and Throat				
Mouth, Teeth, Speech				
Glands				
Chest, Lungs				
Cardiovascular, Heart				
Abdomen				
Genitourinary				
Nervous System, Reflexes				
MUSCULOSKELETAL				
Spine, Back				
*Scoliosis for Grade 7				
Neck				
Back				
Shoulder/arm				
Elbow/forearm				
Wrist/hand/fingers				
Hip/thigh				
Knee				
Leg/ankle				
Foot/toes				

Nutritional status and general appearance of the child _____

□Cleared for all sports without restriction
□Cleared, with recommendations for further evaluation or treatment for: _____
_____
□Not Cleared for □All sports □Certain sports: _____ Reason: _____

Recommendations for additional medical or dental care
_____
_____

Date of Exam _____ Physician's Signature _____
Address _____

PHYSICAL EVALUATION

NAME _____
Last, First M.I.

To be filled by **athletes** prior to tryouts. **Parent** signature required. *Explain "Yes" answers below. Circle questions you don't know the answers to.*
(ONLY APPLIES TO JUNIOR HIGH AND HIGH SCHOOL STUDENTS PARTICIPATING IN CIF SS TEAMS)

	YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has a doctor ever told you that you have (check all that apply): ☐High blood pressure ☐A heart murmur ☐High cholesterol ☐A heart infection		
10. Has a doctor ever ordered a test for your heart?	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:		
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:		
19. Have you had a bone or joint injury that required x-rays MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:		

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand Fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf Shin	Ankle	Foot Toes

20. Have you ever had a stress fracture?	☐	☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐
23. Has a doctor ever told you that you have asthma or allergies?	☐	☐
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25. Is there anyone in your family who has asthma?	☐	☐
26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30. Have you had a herpes skin infection?	☐	☐
31. Have you ever had a head injury or concussion?	☐	☐
32. Have you been hit in the head and been confused or lost your memory?	☐	☐
33. Have you ever had a seizure?	☐	☐
34. Do you have headaches with exercise?	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39. Have you had any problems with your eyes or vision?	☐	☐
40. Do you wear glasses or contact lenses?	☐	☐
41. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42. Are you happy with your weight?	☐	☐
43. Are you trying to gain or lose weight?	☐	☐
44. Has anyone recommended you change your weight or eating habits?	☐	☐
45. Do you limit or carefully control what you eat?	☐	☐
46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐

FEMALES ONLY
47. Have you ever had a menstrual period? ☐ Yes ☐ No
48. How old were you when you had your first menstrual period? _____
49. How many periods have you had in the last 12 months? _____

Explain "Yes" answers here:
_____
_____
_____
_____
_____
_____
_____
_____
_____

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

Signature of Athlete _____ Signature of Parent/Guardian _____

Revised Mar. 16, 2017