



PHYSICAL EVALUATION FORM

LA SIERRA ACADEMY | 4900 GOLDEN AVENUE, RIVERSIDE, CA 92505 | P • 951-351-1445 | F • 951-689-3708

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.

<input type="checkbox"/> Asthma	<input type="checkbox"/> Allergic Rhinitis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Measles	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Other: _____	_____

ALLERGIES: (List all that apply) Students with food allergies must have health care provider fill a 'Food Allergy & Anaphylaxis Care Plan'.

▪ 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.

▪ School Immunization Record

▪ Official Immunization Record from another state

▪ County Health Department Record

PHYSICIAN'S EXAMINATION

Physician's Examination: To be completed by a health care provider for a) all new students entering SECC for the first time, b) all 7th graders (*this should include the scoliosis examination) c) all 9th graders

TB Screening/ Test: Optional

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

TB Screening	Date ____/____/____	TB Clearance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>If No, a TB test is required</i>	
Signature/Agency _____						
TB Skin Test	Type	Date Given	Given By	Date Read	Read By	Impression
	<input type="checkbox"/> PPD Mantoux <input type="checkbox"/> Other _____					<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Chest X-Ray	Film Date ____/____/____	Impression <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal				
Person is free of communicable tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No						
Signature/Agency _____						



PHYSICAL EVALUATION FORM

LA SIERRA ACADEMY | 4900 GOLDEN AVENUE, RIVERSIDE, CA 92505 | P • 951-351-1445 | F • 951-689-3708

Name _____
 Last, First M.I.

PHYSICIAN'S EXAMINATION (CONT.)

	Normal	Abnormal	Not Examined	DESCRIPTION OF ABNORMALITIES
MEDICAL				
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 FORM

LA SIERRA ACADEMY | 4900 GOLDEN AVENUE, RIVERSIDE, CA 92505 | P • 951-351-1445 | F • 951-689-3708

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 | | YES | NO |
|--|-----|----|--|-----|----|
1. Has a doctor ever denied or restricted your participation in sports for any reason? YES NO
 2. Do you have an ongoing medical condition (like diabetes or asthma)? YES NO
 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? YES NO
 4. Do you have allergies to medicines, pollens, foods, or stinging insects? YES NO
 5. Have you ever passed out or nearly passed out DURING exercise? YES NO
 6. Have you ever passed out or nearly passed out AFTER exercise? YES NO
 7. Have you ever had discomfort, pain, or pressure in your chest during exercise? YES NO
 8. Does your heart race or skip beats during exercise? YES NO
 9. Has a doctor ever told you that you have (check all that apply): YES NO
 - High blood pressure A heart murmur
 - High cholesterol A heart infection
 10. Has a doctor ever ordered a test for your heart? YES NO
 11. Has anyone in your family died for no apparent reason? YES NO
 12. Does anyone in your family have a heart problem? YES NO
 13. Has any family member or relative died of heart problems or of sudden death before age 50? YES NO
 14. Does anyone in your family have Marfan syndrome? YES NO
 15. Have you ever spent the night in a hospital? YES NO
 16. Have you ever had surgery? YES NO

25. Is there anyone in your family who has asthma? YES NO
26. Have you ever used an inhaler or taken asthma medicine? YES NO
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? YES NO
28. Have you had infectious mononucleosis (mono) within the last month? YES NO
29. Do you have any rashes, pressure sores, or other skin problems? YES NO
30. Have you had a herpes skin infection? YES NO
31. Have you ever had a head injury or concussion? YES NO
32. Have you been hit in the head and been confused or lost your memory? YES NO
33. Have you ever had a seizure? YES NO
34. Do you have headaches with exercise? YES NO
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? YES NO
36. Have you ever been unable to move your arms or legs after being hit or falling? YES NO
37. When exercising in the heat, do you have severe muscle cramps or become ill? YES NO
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? YES NO
39. Have you had any problems with your eyes or vision? YES NO
40. Do you wear glasses or contact lenses? YES NO
41. Do you wear protective eyewear, such as goggles or a face shield? YES NO
42. Are you happy with your weight? YES NO
43. Are you trying to gain or lose weight? YES NO
44. Has anyone recommended you change your weight or eating habits? YES NO
45. Do you limit or carefully control what you eat? YES NO
46. Do you have any concerns that you would like to discuss with a doctor? YES NO

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:

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? YES NO
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? YES NO
22. Do you regularly use a brace or assistive device? YES NO
23. Has a doctor ever told you that you have asthma or allergies? YES NO
24. Do you cough, wheeze, or have difficulty breathing during or after exercise? YES NO

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 _____