CAPISTRANO UNIFIED SCHOOL DISTRICT
2016-17 ATHLETIC PHYSICAL EXAM

SPORTS: (fall)_____ (winter)_____ (spring)_____

Name _____Grade in 2016-17_____ Male ___ Female___ Date of birth ___/___/____

Address _____ City & Zip Code_____ Phone_____

Father/Guardian _____Work phone _____Cell phone_____

Mother/Guardian _____Work phone _____Cell phone_____

Emergency Contact_____Phone_____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*

Any past or present:	Yes	No
Problems with vision		
Eyeglasses		
Contacts		
Problems with hearing		
Hearing aid		
Blacking out or fainting		
Unconsciousness		
Convulsions, seizures		
Heart problems		
Rheumatic fever		
Bleeding disorders		
Blood sugar problems		
Hypoglycemia		
Diabetes		
Allergies - type _____		
Bee or insect stings		
Hospitalizations		

	Yes	No
Surgeries		
Dental problems		
Braces		
False teeth		
Painful joints		
Broken bones		
Body part, date _____		
Knee or ankle problems		
Require support/brace		
Need for medication		
Name _____		
Menstruation problems		
Hernias		
Asthma		

OTHER HEALTH ASPECTS THE DOCTOR AND SCHOOL SHOULD BE AWARE OF:

_____

_____

	Yes	No
Any history of chest pain with exercise?		
Any history of "racing" heart or skipped beats?		
Do you experience passing out, near passing out or unexpected tiredness during exercise?		
Any family history of sudden cardiac death in a family member under the age of 50?		
Any family history of Marfan's syndrome or prolonged QT syndrome?		
Any history of temporary numbness or paralysis of *both* arms and/or legs following head/spine trauma?		
Any history of recent severe viral illness, infectious mononucleosis, or hepatitis?		
Any history of the following: absence of one kidney?		
males: absence of one testicle?		
Any history of blindness in one eye?		
Any current active skin infection?		

PHYSICAL EXAM: DATE _____ HEIGHT _____ WEIGHT _____

PULSE: RESTING _____ AFTER ACTIVITY _____ B.P. _____

EYES	____	THROAT	____	ABDOMEN	____	ORTHOPEDIC	____
EARS	____	LYMPH GLANDS	____	HERNIA	____	SKIN	____
TEETH	____	THYROID	____	POSTURE	____	OTHER	____
BRACES	____	HEART	____	MUSCLE TONE	____		
NOSE	____	LUNGS	____	REFLEXES	____		

Special doctor recommendations or restrictions _____

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

(Must be signed by a PHYSICIAN, PHYSICIAN'S ASSISTANT or NURSE PRACTITIONER.*)*

Name of physician _____MD/DO/PA/NP Date_____

Signature _____ Phone_____

**Physician's Office Stamp*