

**ELK GROVE UNIFIED SCHOOL DISTRICT - SPORTS PHYSICAL**

<b>PART 1 (TO BE COMPLETED BY STUDENT AND PARENT(S OR GUARDIAN))</b>						
LAST NAME		FIRST NAME			GRADE	
BIRTHDATE	FALL SPORT	WINTER SPORT	SPRING SPORT	STUDENT ID NUMBER		
<b>HEALTH HISTORY (Must be completed prior to the examination)</b>						
	<b>Yes</b>	<b>No</b>	<b>Has this student had any:</b>	<b>Yes</b>	<b>No</b>	<b>Does this student:</b>
1.	<input type="checkbox"/>	<input type="checkbox"/>	Chronic or recurrent illness?	<input type="checkbox"/>	<input type="checkbox"/>	Wear eyeglasses or contact lenses?
2.	<input type="checkbox"/>	<input type="checkbox"/>	Illness lasting over 1 week?	<input type="checkbox"/>	<input type="checkbox"/>	Wear dental bridges, braces or plates?
3.	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalizations?	<input type="checkbox"/>	<input type="checkbox"/>	Take any medications? Please list:
4.	<input type="checkbox"/>	<input type="checkbox"/>	Surgery other than removal of tonsils?			_____
5.	<input type="checkbox"/>	<input type="checkbox"/>	Missing organs (eye, kidney, testicle)?	<b>Yes</b>	<b>No</b>	<b>Is there any history of:</b>
6.	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (medicines, insect bites, food)?	<input type="checkbox"/>	<input type="checkbox"/>	Injuries requiring physical treatment?
7.	<input type="checkbox"/>	<input type="checkbox"/>	Problems with heart or blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Neck or back injury?
8.	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain or severe shortness of breath with exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Knee injury?
9.	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting with exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder or elbow injury?
10.	<input type="checkbox"/>	<input type="checkbox"/>	Fainting, bad headaches or convulsions?	<input type="checkbox"/>	<input type="checkbox"/>	Ankle injury?
11.	<input type="checkbox"/>	<input type="checkbox"/>	Concussion or loss of consciousness?	<input type="checkbox"/>	<input type="checkbox"/>	Other serious joint injury?
12.	<input type="checkbox"/>	<input type="checkbox"/>	Heat exhaustion, heatstroke, or other problems with heat?	<b>Yes</b>	<b>No</b>	<b>Further history:</b>
13.	<input type="checkbox"/>	<input type="checkbox"/>	Racing heart, skipped, irregular heartbeats, or heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	Is there any reason why this student should not participate in sports?
14.	<input type="checkbox"/>	<input type="checkbox"/>	Seizures?	<input type="checkbox"/>	<input type="checkbox"/>	Has any family member died suddenly at less than 40 years of age of causes other than an accident?
15.	<input type="checkbox"/>	<input type="checkbox"/>	Muscle cramps?	<input type="checkbox"/>	<input type="checkbox"/>	Has any family member had a heart attack at less than 55 years of age?
<u>Explanation of all "YES" answers:</u>						
Date of last known tetanus (lockjaw) shot: _____						

**PARENT(S) OR GUARDIAN'S ACKNOWLEDGEMENT AND PERMISSION:** I have reviewed and agree with the above information. I know of no reason why the above named student may not participate and represent his or her school in supervised athletic activities and I authorize a physician to perform this screening examination. Therefore, I give my permission for this student to participate in athletics and guarantee that he/she has sufficient medical insurance. **I will contact the athletic director if my student does not have medical insurance so I can purchase alternative insurance.**

PRINT NAME OF PARENT OR GUARDIAN		SIGNATURE OF PARENT OR GUARDIAN		
ADDRESS		WORK PHONE	HOME PHONE	DATE
PHYSICIAN'S NAME	OFFICE PHONE	MEDICAL INSURANCE COMPANY & POLICY NUMBER		

<b>PART 11 (TO BE COMPLETED BY THE EXAMINING PHYSICIAN)</b>			
	NORMAL	ABNORMAL (Describe)	
Eyes/Ears/Nose/Throat			Height:
Skin			Weight:
Heart			Pulse:                      After Ex:
Abdomen			BP:
Genitalia/hernia (males)			<b><u>Recommendation:</u></b> <input type="checkbox"/> Unlimited participation <input type="checkbox"/> Participation limited to specific sports <input type="checkbox"/> Clearance withheld pending further evaluation <input type="checkbox"/> No athletic participation  <i>One of the above <b><u>MUST</u></b> be checked.</i>
Musculoskeletal:			
a. Neck			
b. Spine			
c. Shoulders			
d. Arms/Hands			
e. Hips			
f. Thighs			
g. Knees			
h. Ankles			
i. Feet			
<b>Comments:</b>			
PRINT NAME OF PHYSICIAN		PHYSICIAN'S SIGNATURE	
		DATE	

**NOTICE: THIS EXAMINATION DOES NOT CONSTITUTE A COMPLETE PHYSICAL EXAMINATION.** It does, on this date, based on the observations of the physician, meet the requirements for the herein named student to participate in school sports activities. If you have any health concerns related to your student, be sure to bring those concerns specifically to the attention of your own physician. **The required physical needs to be renewed annually after June 1.**