POWAY UNIFIED SCHOOL DISTRICT

Athletic Screening History & Physical Exam

Student Name:	Date of Birth:
Address:	City/Zip:
Home Phone:	High School Graduating Class (Year):
Father's Work Phone:	Mother's Work Phone:
Emergency Contact/Phone:	Emergency Contact/Phone:

EXPLANATION OF SCREENING PHYSICAL

I realize that the medical evaluations performed are only screens in order to evaluate general health, to disclose existing problems, and to determine my son/daughter's dynamic ability to participate in a given sport so that obvious conditions which might be damaged or aggravated by competitive sports can be found, evaluated and treated so as to prevent further injury. This examination does not guarantee against injury.

Parent Initials _____

AWARENESS OF RISK

STUDENT AND PARENT – I am aware that playing/practicing sports can be a dangerous activity involving many risks of injury. I understand that the risks of participation include, but are not limited to, death, serious neck and spinal cord injuries that may result in complete or partial paralysis, brain damage, serious internal injury to virtually any internal organs, bones, joints, muscles, tendons, or any other aspect of the skeletal system, and serious injury or impairment to other aspects of my body, general health and well being. I understand that the risks of participation may result not only in serious injury, but in impairment of my future ability to earn a living, to engage in other business, social and recreational activities, and generally to enjoy a good life. Because of the dangers of participating in sports, I recognize the importance of following coaches' instructions regarding playing techniques, training, equipment and other team rules, etc. both in competition and practice and agree to obey such instructions.

Parent Initials _____

PERMISSION FOR TREATMENT

I hereby grant permission to the team physicians and those professional personnel designated by Poway Unified School District to treat my son/daughter in the event of an injury. In the event of a serious injury, if I am unable to give my consent at the time, this consent is to include any and all emergency procedures deemed necessary by the attending emergency personnel. I also understand that in the event of injury, every reasonable attempt will be made to contact me prior to securing medical treatment beyond basic first-aid.

Parent Initials _____

PROOF OF INSURANCE

In compliance with California Education Code 32221, I certify that there is in effect at this time insurance coverage for medical expenses resulting from bodily injury of at least $5,000 for my son/daughter, and that this coverage will remain in effect throughout the time that he/she participates in sports. I also give my permission for the above named student to participate in sports, including regularly scheduled trips by supervised school transportation.

Parent Initials _____ Insurance Carrier _____ Policy # _____

I have read the above statements, EXPLANATION OF SCREENING PHYSICAL, AWARENESS OF RISK, and PERMISSION FOR TREATMENT, and understand them fully and agree/consent to their contents.

Parent Signature _____ Date _____

Student Signature _____ Date _____

Student Name: _____

Health History - Please answer the following in the check box provided. Explain "yes" answers in the box below.

1. Have you ever been hospitalized (overnight)? [ ] Yes [ ] No
   Have you ever had surgery? [ ] Yes [ ] No
2. Are you currently taking medication? [ ] Yes [ ] No
3. Do you have any allergies (medicines, pollen, bees)? [ ] Yes [ ] No
4. Have you ever passed out during exercise? (not from heat) [ ] Yes [ ] No
   Have you ever been dizzy during exercise? (not from heat) [ ] Yes [ ] No
   Have you ever had chest pain? [ ] Yes [ ] No
   Do you tire more quickly than your friends during exercise? [ ] Yes [ ] No
   Have you ever had high blood pressure? [ ] Yes [ ] No
   Have you ever been told you had a heart murmur? [ ] Yes [ ] No
   Have you ever had racing of your heart or skipped beats? [ ] Yes [ ] No
   Has anyone in your family died of heart problems or a sudden death before age 40? [ ] Yes [ ] No
   Does anyone in your family have Marfan's Syndrome? [ ] Yes [ ] No
5. Do you have any skin problems (itching, rashes, breaking out)? [ ] Yes [ ] No
6. Have you ever had a head injury? [ ] Yes [ ] No
   Have you ever been knocked out? [ ] Yes [No
   Have you ever had a seizure? [ ] Yes [ ] No
   Have you ever had a burner/stinger? (pain from neck to arm) [ ] Yes [ ] No
7. Have you ever had heat cramps? [ ] Yes [ ] No
   Have you ever been dizzy or passed out in the heat? [ ] Yes [ ] No
8. Do you use special pads or braces? [ ] Yes [ ] No
9. Have you ever injured (broken/fractured, sprained, dislocated):

   [ ] Hand/fingers [ ] Shoulder [ ] Hip [ ] Shin/calf
   [ ] Wrist/forearm [ ] Neck [ ] Thigh [ ] Ankle
   [ ] Elbow [ ] Chest/ribs [ ] Knee [ ] Foot/toes
   [ ] Upper arm [ ] Back [ ] Stress fractures? _____

10. Have you ever had:

    [ ] Mononucleosis [ ] Diabetes [ ] Measles [ ] Hernia(s)
    [ ] Hepatitis [ ] Headaches (frequent) [ ] Asthma [ ] Ulcers
    [ ] Eye/ear injuries [ ] Tuberculosis [ ] Sickle cell trait/disease

11. When was your last tetanus shot? _____
12. About your weight: Do you think you are… [ ] just right? [ ] too heavy? [ ] too light/thin?
    Do you like to drink dairy (milk) products? [ ] Yes [ ] No
    For females:
    When was your first period and how old were you? _____
    When was your last period? _____
    Are your periods [ ] Regular/monthly? [ ] Irregular/skip months?
13. **Please ask the doctor to address any questions that you may have. [All discussions are kept confidential.]**

Please explain any "yes" answers here:

Student Name: _____

14. Circle the sports you are interested in:

Baseball	Field Hockey	Lacrosse	Swim/Dive	Water Polo
Basketball	Football	Roller Hockey	Track/Field	Wrestling
Cheerleading	Golf	Soccer	Tennis	
Cross Country	Gymnastics	Softball	Volleyball	

Other(s): _____

Physical Examination

(To be completed by Medical Personnel)

Height _____ Blood Pressure _____ (sitting, left arm)

Weight _____ Pulse _____

Body fat _____% (optional)

Vision (optional)
Left eye 20/ ____
Right eye 20/ ____
Both eyes 20/ ____
with / without glasses

1. Skin	
2. Head	
3. Eyes (PERLA, EOMI, Fungi)	
4. Ears, nose, throat	
5. Neck	
6. Lymphatic's	
7. Respiratory	
8. Cardiovascular	
Heart (murmurs?)	
9. Abdomen	
10. Genitalia (include. hernia exam – optional)	
11. Extremities	
12. Neurologic	
Reflexes	
13. Orthopedic	
Cervical spine/back	
Arms/elbows/wrist/hands	
Hips	
Knees	
Ankles/feet	
14. Developmental	
Tanner staging 1 – 5 (optional	

√ = within normal limits
+ = see comments
X = omitted

Comments/Recommendations:

Student Name: _____

MEDICAL CLEARANCE
(As appropriate for age and development)

[ ] Full contact/collision level (full, unrestricted participation)

[ ] Limited contact/impact

[ ] Non contact: strenuous

[ ] Non contact: non-strenuous

[ ] Clearance deferred or no participation at this time because:

[ ] Needs clearance by specialist

[ ] Orthopedist [ ] Cardiologist

Other: _____

[ ] Needs to complete rehabilitation for current condition(s) prior to participation

Patient Education provided:

( ) Stretching emphasized ( ) Discussed prevention of sun/heat-related problems

( ) Discussed fitness/ideal weight ( ) Discussed treatment of acute injuries ( ) Discussed testicular cancer exams

Physician's Statement:

(Student's name)_____was examined by me on _____(date) and found physically fit to engage in high school athletics. Results are to encourage, but in no way guarantee, the fitness and safety of this athlete.

Practitioner Signature: _____ Date_____

M.D. / D.O. / N.P. / P.A. / D.C.

Do not sign without student's name filled in

Physician's Office Stamp HERE
(REQUIRED)

RESIDENCE & ELIGIBILITY VERIFICATION

To be completed by individual with whom student resides

Student Name:	**Grade:**	**Home #:**
Address:	**DOB:**	**Parent Cell #:**
City/Zip:	**Age:**	**Parent Cell #:**

1. I am the one with whom this student-athlete **resides**: (check one box)

   ☐ Parent ☐ Legal Guardian ☐ Relative ☐ Caretaker ☐ Foster Parent ☐ Emancipated Minor

2. Is this the same residence this athlete had last year? ☐ Yes ☐ No - Previous Address:_____

3. Student Status:

   ☐ Continuing Student ☐ Incoming 9th Grader ☐ New Resident ☐ Administrative Placement ☐ Intra-District Transfer ☐ Inter-District Transfer

4. School attended last year if athlete is **new and came from another high school**:

   _____ _____ _____
   Name of School Address City/State/Zip

   _____
   Sports played at previous school and level of play (varsity, JV, freshman)

   a. Did anyone influence this student to come to this school? ☐ Yes (explain)_____ ☐ No
   b. Has there been contact with anyone from this school within the past 24 months? ☐ Yes (explain)_____ ☐ No
   c. Did he/she move with the same family members, caregivers or legal guardians? ☐ Yes ☐ No
   d. Did discipline issues require the athlete to leave his/her former school? ☐ Yes ☐ No

5. I verify that this street address is within the High School boundaries and/or I have followed the District transfer procedures.
   I also understand that falsifying this information may cause immediate ineligibility for two years and team forfeiture.

_____
Print Name of Person Checked on Line 1

X _____ _____ **X** _____ _____
Signature of Person with Whom Student/Athlete Resides Date **Student/Athlete Signature** Date

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ATHLETIC HANDBOOK

I have reviewed and agree to abide by the guidelines/policies in the Athletic Handbook which is posted on school website. I acknowledge that it is my responsibility to read and understand these rules and discuss them with my parent/guardian/athlete. **Parent Initials** _____ **Student/Athlete Initials** _____

CIF CONCUSSION INFORMATION

I agree that the safety of the athletes always come first. I have read the CIF Concussion Information Sheet posted on the school website and am familiar with the signs and symptoms of a concussion. I understand and support the decision that any athlete suspected of suffering a serious head injury may be removed from a game or practice immediately and will not be allowed to return to activity until medically cleared. **Parent Initials** _____ **Student/Athlete Initials** _____

ATHLETIC POLICY AGAINST HAZING

Poway Unified School District strives to maintain a healthy athletic program in which all students feel safe, welcome and proud of the school and the athletic programs that they represent. I understand that hazing of any kind is not allowed on this campus and in the athletic program. This includes mental, verbal and physical acts. I further understand that it is my duty to report any acts of hazing that I see to a coach or administrator on campus. I agree to uphold this District policy and understand that any violation will result in my immediate suspension from athletics and further disciplinary action as outlined in District policy and procedures.
Parent Initials _____ **Student/Athlete Initials** _____

ETHICS IN SPORTS POLICY

I accept and understand the Policy Statement, Code of Ethics, The Pillars and Principles of Pursuing Victory With Honor, and the Violations, Minimum Penalties, and Appeal Process of the CIF- San Diego Section ETHICS IN SPORTS Policy posted on the cifsds.org website. I agree to abide by this policy while participating and/or spectating at CIFSDS athletic events regardless of contest site or jurisdiction. **Parent Initials** _____ **Student/Athlete Initials**_____

MEDIA RELEASE

I understand that my name, picture, and/or grade point average may be released to the media. **Parent Initials** _____ **Student/Athlete Initials** _____

I have read all of the above statements and understand them fully and agree/consent to their contents.

X_____ **X**_____
Parent/Guardian Signature **Student/Athlete Signature**

MEDICAL INFORMATION RELEASE FORM FOR CO-CURRICULAR ACTIVITY

This form is provided to the coach and will be taken with the team wherever they travel. Please **fill it out completely and be specific**.
The form gives parental consent for any staff/chaperone approved by the school principal to secure emergency services (medical, dental, paramedic, ambulance) for the student at the parent/guardian expense. Efforts will be made to contact the parent/guardian prior to treatment or hospitalization.
An authorization with a physician's signature must be attached if the athlete takes any prescription medication.

Student Name:	Sport(s):	
Parent/Guardian Name:	Graduating Year:	
Address:	City/ZIP	
Home Phone:	Mother Cell:	Mother Work:
	Father Cell:	Father Work:

IN CASE OF EMERGENCY, A REPRESENTATIVE OF THE PUSD ATHLETIC DEPARTMENT HAS THE AUTHORITY TO SECURE MEDICAL OR SURGICAL TREATMENT AND TRANSPORT AS NECESSARY. EVERY ATTEMPT WILL BE MADE TO CONTACT THE EMERGENCY PERSONS LISTED BELOW.

Family Doctor:	Dr. Phone #:
Emergency Person to Contact:	Phone #:
Relationship to Student:	
Emergency Person to Contact:	Phone #:
Relationship to Student:	

List all information helpful to a physician in case of emergency including information which school staff and chaperones need to be aware of regarding the student's safety. Updated information shall be provided by the parent/guardian.

MEDICAL PROBLEMS: (diabetes, asthma, seizures)	TREATMENT:
ALLERGIES: (food, bee stings, medication)	TREATMENT:

SCHOOL RULES ARE IN EFFECT FOR ALL SCHOOL SPONSORED ACTIVITIES

MEDICATION: Prescription and non-prescription medications are permitted only with a written statement from the physician and parent/guardian indicating desire that the District assist the student as set forth by the physician. If prescription or non-prescription medication is necessary, an AUTHORIZATION FOR MEDICATION ADMINISTRATION must be attached. I understand that staff/chaperones may assist my student in taking the medicine(s) as directed by my physician. I will provide the medicine(s) in the prescription container(s) labeled with the name of my student, the prescribing physician's name, and the time and dosage of medication prescribed. I agree to hold harmless and indemnify the Poway Unified School District, its officers, employees, agents or chaperones from and against any and all liability, loss, expense or claims for illness, injury or damage any student may incur from medication assistance.

I UNDERSTAND THAT BY SIGNING THIS FORM:

1. I give permission for my son or daughter to participate in Poway Unified School District athletics.
2. I give permission for staff/chaperones to provide first aid care and secure emergency care at my expense if needed.
3. I release the Poway Unified School District, its officers, employees, agents and its chaperones from any and all liability, loss, expense or claim for illness, injury or damages that may arise from participation in the athletics program or any associated activity. Further, I understand that the District does not provide accident/medical insurance for students and that I am expected to provide such insurance coverage.
4. I am aware that injuries may occur to the athlete while participating in interscholastic athletics. I have been advised of this danger.

_____ _____
Name of Insurance Company Insurance Policy/Group Number

X_____ _____
Parent/Guardian Signature **Date** **Printed Name of Parent/Guardian**