SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT
25631 Peter A. Hartman Way, Mission Viejo, CA 92691

MALE ☐
FEMALE ☐

SPORT(S) I PLAN ON PARTICIPATING IN THIS YEAR:

☐ Fall: ____________ ☐ Winter: ____________ ☐ Spring: ____________

ATHLETIC PRE-PARTICIPATION HEALTH HISTORY

Name ______________________ **Grade** ______ **Date** ____________

Address ______________________ **D.O.B.** ______ **Phone** ____________

HEALTH HISTORY TO BE COMPLETED BY PARENT OR GUARDIAN *AND REVIEWED BY EXAMINING PHYSICIAN*
ANSWER ALL QUESTIONS BY CIRCLING "YES" OR "NO"

1. Respiratory problems (Asthma) .... YES NO
   a. Do you cough or wheeze with exercise? .... YES NO
   b. Are you under medical care for asthma? Physician's Name ____________ YES NO
   c. Do you use an inhaler? .... YES NO
   d. How often do you use rescue inhaler for relief: # per day _____; # per week _____
2. Has had an injury of a muscle, bone, joint, ligament or tendon? .... YES NO
   Medical attention required? When? ____________
   What? ____________
3. Has been knocked out. If YES, how many times? ________ .... YES NO
4. Has fainted. If YES, how many times? ________ .... YES NO
5. History of seizures (convulsions/epilepsy) .... YES NO
6. Diabetes (Student carries low blood sugar supplies) .... YES NO
7. Rheumatic Fever .... YES NO
8. Absent or undescended testicle .... YES NO
9. Hernia .... YES NO
10. Is under a physician's care now .... YES NO
11. Takes any medications now. Medication(s) ____________ YES NO
12. Wears glasses or contacts. If YES, which? ________ .... YES NO
13. Dental bridge or false teeth? .... YES NO
14. Has had surgical operation .... YES NO
15. Has been in a hospital (except for tonsillectomy) .... YES NO
16. Any reason why this student should not participate in any sport? .... YES NO
17. Any allergies (bee stings, foods, etc.) .... YES NO
18. Difficult menses .... YES NO

Please explain any "YES" answers: ______________________________

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______________________________ ______________________________
Signature of Parent or Legal Guardian Date

REVERSE SIDE TO BE COMPLETED BY EXAMINING PHYSICIAN

HEALTH EXAMINATION FORM
(To be completed by examining physician)

Name ____ **D.O.B.** ________________
(Last) *(First)*

Height __________ **Weight** __________ **Blood Pressure** ______________ **Pulse** ______________

Eyes: R 20/______ **L 20/**______ **Glasses** ______________ **Contact Lenses** ______________

Ears ____________________ **Nose** ____________________ **Throat** ____________________

Dental Evaluation ____
(Missing teeth? False teeth? Chipped teeth? Dental bridge?)

Lung Evaluation (i.e. asthma): Peak Flow __________ Passed: ❑ Yes ❑ No*
Personal Best

Cardiovascular Abnormalities? ____

Musculoskeletal Evaluation:

Neck, shoulder girdle or upper extremity ________________________________

Abnormalities? ________________________________

Limitation of movement? ________________________________

Trunk ________________________________

Rib abnormalities? ________________________________

Thigh and Bone ________________________________

Hamstring or quadriceps abnormalities? ________________________________

Knee ligament and stability? ________________________________

Knee joint effusion or crepitation? ________________________________

Calf, ankle and foot ________________________________

Achilles tendon disorder? ________________________________

Ankle ligament stability? ________________________________

Ankle joint effusion or crepitation? ________________________________

Foot problems? ________________________________

Limitation of movement? ________________________________

Neurological Evaluation: ____

Genitalia: ____

Laboratory: Urinalysis ____

Health History (on reverse) was reviewed and I examined this student on ________________. *No physical condition was detected which would reasonably be anticipated to render this athlete physically unfit to engage in any sport except* ________________________. *(If none, please state "None.")*

______ *** Student Participation Is Pending Spirometry / Pulmonary Function Test Results**

Examining Physician ______________________________ **Date** ______________

Address ______________________________ **Phone** ______________