PLACENTIA-YORBA LINDA UNIFIED SCHOOL DISTRICT

SPORTS PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

Pages 1-2 of this Form should be placed into the Student's medical file and should not be shared with schools or sports organizations.

Student Name: _____ Date of Birth: _____ Age: _____ Sex: _____ Grade: _____

School: _____ Student ID #: _____ Phone Number: _____

Address: _____ Primary Care Provider: _____

Emergency Contacts: _____

Check sport(s) of participation: ☐Band ☐Baseball ☐Basketball ☐Cheer ☐Color Guard ☐Cross Country ☐Dance ☐Football ☐Girls Beach Volleyball ☐Girls Flag Football ☐Golf ☐Lacrosse ☐Soccer ☐Softball ☐Song ☐Swimming ☐Tennis ☐Track & Field ☐Volleyball ☐Water Polo ☐Wrestling ☐Other:_____

REQUIRED HEALTH HISTORY – TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN ON BEHALF OF STUDENT

Has your child: (If you answer "YES" to any of these questions, please explain in detail in the box provided below. If you need additional room, please include an attachment.)

1. Do you have or have you had any chronic illness, ongoing medical issues, or recent illness? ☐Asthma ☐Diabetes ☐Frequent Headaches ☐Bleeding Disorder ☐Other	☐YES	☐NO	19. Have you ever had heat cramps, heat exhaustion, or become ill while exercising in the heat?	☐YES	☐NO
2. Have you ever been hospitalized overnight? If yes, please provide the diagnosis in the box provided below.	☐YES	☐NO	20. Have you ever broken/fractured, sprained, or dislocated a body part? If yes, please list body part(s) and date(s) of injury in the box provided below.	☐YES	☐NO
3. Has a provider ever denied or restricted your participation in sports for any reason?	☐YES	☐NO	21. Do you have a bone, muscle, ligament, tendon, or joint injury that bothers you?	☐YES	☐NO
4. Do you use special equipment? ☐Pads ☐Braces ☐Orthotics ☐Prostheses ☐Other	☐YES	☐NO	22. Are you missing any organ or limb? If yes, please list body part(s) and date(s) of loss in the box provided below.	☐YES	☐NO
5. Do you cough, wheeze, have shortness of breath, or have difficulty breathing during or after exercise?	☐YES	☐NO	23. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	☐YES	☐NO
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	☐YES	☐NO	24. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?	☐YES	☐NO
7. Do you get light-headed, dizzy, or become tired more quickly than peers during exercise?	☐YES	☐NO	25. Do you or does someone in your family have sickle cell trait or disease?	☐YES	☐NO
8. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	☐YES	☐NO	26. Have you ever had or do you have any problems with your eyes or vision?	☐YES	☐NO
9. Has a doctor ever told you that you have any heart problems, heart murmur, or heart disease?	☐YES	☐NO	27. Do you eat a healthy well balanced diet?	☐YES	☐NO
10. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	☐YES	☐NO	28. Do you have to gain or lose weight to meet the requirements of your sport(s)?	☐YES	☐NO
11. Has anyone in your family developed heart disease or died from heart problems under age 40?	☐YES	☐NO	29. Do you worry about your weight?	☐YES	☐NO
12. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	☐YES	☐NO	30. Are you trying to or has anyone recommended that you gain or lose weight?	☐YES	☐NO
13. Has anyone in your family had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?	☐YES	☐NO	31. Are you on a special diet or do you avoid certain types of foods or food groups?	☐YES	☐NO
14. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?	☐YES	☐NO	32. Have you ever had an eating disorder?	☐YES	☐NO
			33. Are you up to date with all California immunization requirements?	☐YES	☐NO
			34. Do you have any concerns that you would like to discuss with your provider?	☐YES	☐NO
			35. Are you currently taking any prescription or over-the-counter medications or using an inhaler or EpiPen? If yes, please list them in the box provided below.	☐YES	☐NO
15. Have you ever had more than one episode of burner/stinger (pain from neck into arm)?	☐YES	☐NO	36. Do you have any allergies? If yes, please identify all allergies including, but not limited to, medication, pollens, food, etc. in the box provided below.	☐YES	☐NO
16. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?	☐YES	☐NO			
17. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?	☐YES	☐NO	37. For females: How old were you when you had your first menstrual period?		
18. Have you ever passed out or had a seizure?	☐YES	☐NO	38. For females: Are your periods: ☐Regular/Monthly ☐Irregular ☐Absent?		

If you have answered "YES" to any of the above questions, please explain:

ATTESTATION

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Parent/Legal Guardian Signature: _____ Date: _____

PLACENTIA-YORBA LINDA UNIFIED SCHOOL DISTRICT

SPORTS PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

EXAMINATION FORM – TO BE COMPLETED BY HEALTH CARE PROVIDER	
Height:	Weight:
Blood Pressure:	Pulse:
Body Habitus:	
Visual Acuity (Distance): Right: / Left: / Both Eyes: / ☐ Corrected ☐ Uncorrected	

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, Ears, Nose, and Throat • Pupils Equal, Hearing		
Head		
Abdomen		
Lungs		
Lymph Nodes		
Heart* • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) *Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis		
Genitalia/Hernia		
Neurological		

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Cervical Spine/Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

HEALTH CARE PROVIDER REMINDERS/DISCUSSION ITEMS
Discussed Fitness/Ideal Weight
Discussed Mental Health
Discussed Prevention of Sun/Heat-Related Problems
Discussed Treatment of Injuries
Discussed Testicular Cancer Exams
Stretching Emphasized

HEALTH CARE PROVIDER COMMENTS

Health Care Provider Name: _____, MD/DO/NP/PA (circle one)

Signature: _____ Date: _____

Address: _____ Phone: _____

Health Care Provider Office Stamp (Required):

PLACENTIA-YORBA LINDA UNIFIED SCHOOL DISTRICT

SPORTS MEDICAL ELIGIBILITY FORM

This Sports Medical Eligibility Form should be placed into the Student's medical file and shared with schools or sports organizations.

Student Name: _____ Date of Birth: _____ Age: _____ Sex: _____ Grade: _____

School: _____ Student ID #: _____ Phone Number: _____

Address: _____ Primary Care Provider: _____

Emergency Contacts: _____

Check sport(s) of participation: ☐Band ☐Baseball ☐Basketball ☐Cheer ☐Color Guard ☐Cross Country ☐Dance ☐Football ☐Girls Beach Volleyball ☐Girls Flag Football ☐Golf ☐Lacrosse ☐Soccer ☐Softball ☐Song ☐Swimming ☐Tennis ☐Track & Field ☐Volleyball ☐Water Polo ☐Wrestling ☐Other:_____

MEDICAL ELIGIBILITY – TO BE COMPLETED BY HEALTH CARE PROVIDER

☐ Medically eligible for all sports without restriction.

☐ Medically eligible for all sports without restriction with recommendations for further examination or treatment of:

_____

_____

☐ Medically eligible for certain sports:

_____

_____

☐ Not medically eligible pending further examination.

☐ Not medically eligible for any sports. Recommendations:_____

_____

_____

ATTESTATION

I have examined the Student named on this form and completed the pre-participation physical examination. The Student does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings, including the completed Sports Pre-Participation Physical Examination Form, are on record in my office and can be made available to the school at the request of the Parent or Legal Guardian. If conditions arise after the Student has been cleared for participation, the Health Care Provider may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the Student (and Parent or Legal Guardian).

Health Care Provider Name: _____, MD/DO/NP/PA (circle one)

Signature: _____ Date: _____

Address: _____ Phone: _____

Health Care Provider Office Stamp (Required):

Shared Emergency Information – To Be Completed by Parent or Legal Guardian

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other Information: _____

_____

_____

Emergency Contacts: _____

_____

_____