

Centinela Valley Union High School District Preparticipation Physical Evaluation

Female ___ Male ___
Year _____
ID# _____

Print Last Name	First Name	Middle Initial	Grade	Sport
Address	City	Zip	Home Phone Number	
Father/Guardian's Name	Father/Guardian's Phone Number	Mother/Guardian's Name	Mother/Guardian's Phone No.	
Father's Work Number	Mother's Work Number	Others to Call in Emergency (Name and Phone Number)		

HEALTH HISTORY (To be completed by student & parent): Check "yes" or "no" and give as much information as possible.

Yes No Heart Trouble
 Yes No Asthma
 Yes No Diabetes
 Yes No Seizures
 Yes No Palpitations
 Yes No Fatigue
 Yes No High Blood Pressure
 Yes No Chest Pain
 Yes No Current Skin Condition
 Yes No Dizziness/Fainting
 Yes No Extreme Shortness of Breath/Wheezing
 Yes No Kidney Problems
 Yes No History of family member with heart attack under 50yrs of age or sudden death.
 Yes No Other: Glasses/Contacts, Protective Equipment, or Hearing Aid
 Yes No Head Trauma/Loss of Consciousness

Other: _____

History of any previous injuries, fractures, serious illnesses or operations/hospitalizations (describe and give approximate dates)

Current medications _____ Allergies _____ Date of Last Tetanus Shot _____

PARENT CONSENT

I hereby state that the above information is true and correct and give my consent for the above-named student to compete in sports and go with a representative of the school on any trips. In case of injury, the school representative is authorized to have him/her treated.

▶ _____	▶ _____	▶ _____	▶ _____
Date	Parent/Guardian Signature	Name of Insurance Co.	Policy/Group Number

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PHYSICAL EXAMINATION (To be completed by physician):

Visual Acuity (Distance): O.D. _____ / _____ O.S. _____ / _____ () Corrected () Uncorrected
 Height _____ Weight _____ Blood Pressure _____ Pulse _____

Normal	Normal
1. Eyes, Ears, Nose, Throat	9. Musculoskeletal
2. Neck	Neck
3. Cardiovascular	Spine
EKG results (if done)	Shoulders
4. Chest and Lungs	Arms/Hands
5. Abdomen	Hips
6. Skin	Thighs
7. Genitalia-Hernia (male)	Knees
8. Neuromuscular	Ankles
	Feet

Comments: _____

RECOMMENDATION: () Full Activity – No restrictions
 () Activity with restrictions:
 () No contact sports () No Participation
 () Other _____

EXAMINING PHYSICIAN: Phone: ▶ _____

DATE OF EXAM: ▶ _____ **LICENSE #:** ▶ _____

Print name: ▶ _____

Signature: ▶ _____

PHYSICIAN'S STAMP