**TWIN RIVERS UNIFIED SCHOOL DISTRICT**
**SPORTS PHYSICAL EXAMINATION FORM**

**PART 1 (TO BE COMPLETED BY A PARENT OR LEGAL GUARDIAN)**

**LAST NAME** | **FIRST NAME** | **GRADE**
---|---|---

**BIRTHDATE**

**FALL SPORT** | **WINTER SPORT** | **SPRING SPORT**
---|---|---

**PART 1 -- HEALTH HISTORY (Must be Completed by Parent/Guardian Prior to the Examination)**

<table>
<thead>
<tr>
<th><strong>YES</strong></th>
<th><strong>NO</strong></th>
<th><strong>YES</strong></th>
<th><strong>NO</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong></td>
<td>Chronic or recurrent illness?</td>
<td><strong>16</strong></td>
<td>Injuries requiring medical care or treatment?</td>
</tr>
<tr>
<td><strong>2</strong></td>
<td>Illness lasting over one (1) week?</td>
<td><strong>17</strong></td>
<td>Neck or back pain or injury?</td>
</tr>
<tr>
<td><strong>3</strong></td>
<td>Hospitalizations or surgeries?</td>
<td><strong>18</strong></td>
<td>Knee pain or injury?</td>
</tr>
<tr>
<td><strong>4</strong></td>
<td>Nervous, psychiatric or neurologic conditions?</td>
<td><strong>19</strong></td>
<td>Should or elbow pain or injury?</td>
</tr>
<tr>
<td><strong>5</strong></td>
<td>Loss of nonfunctioning of organs (eye, kidney, liver, testicle or glands)?</td>
<td><strong>20</strong></td>
<td>Ankle pain or injury?</td>
</tr>
<tr>
<td><strong>6</strong></td>
<td>Allergies to medicines, insect bites or food?</td>
<td><strong>21</strong></td>
<td>Other joint pain or injury?</td>
</tr>
<tr>
<td><strong>7</strong></td>
<td>Problems with heart or blood pressure?</td>
<td><strong>22</strong></td>
<td>Broken bones (fractures)?</td>
</tr>
</tbody>
</table>
| **8** | Chest pain or significant or severe shortness of breath during or after exercise? | **YES** | **NO** | Does this student presently:
| **9** | Dizziness or fainting with exercise? | **23** | Wear eyeglasses or contact lenses? |
| **10** | Fainting, bad headaches or convulsions? | **24** | Wear dental bridges, braces or plates? |
| **11** | Potential concussion or loss of consciousness? | **25** | Take any medication? (List below) |
| **12** | Heat exhaustion, heatstroke, or other problems managing or responding to heat? | **YES** | **NO** | Further history: |
| **13** | Racing heartbeat, skipped or irregular heartbeats, or heart murmur? | **26** | Birth defects (corrected or not)? |
| **14** | Seizures or seizure disorders? | **27** | Death of parent/grandparent less than 40 years of age due to medical cause or condition? |
| **15** | Severe or repeated instances of muscle cramps? | **28** | Parent/grandparent requiring treatment for heart condition less than 50 years of age? |
| **16** | Injuries requiring medical care or treatment? | **29** | Been seen by a physician on an emergency or urgent basis in the last 12 months? |

**Date of last known tetanus (lockjaw) shot:**

**Date of last complete physical examination:**

*Explain all "YES." Describe any other fact that should be disclosed prior to the examination (use reverse of form if needed)*

**PARENT/GUARDIAN’S AUTHORIZATION:** I authorize the health care provider to perform a Sports Physical Evaluation on the student. The information set forth above is complete and accurate. I presently know of no reason why the student cannot fully and safely participate in the listed sports. For Sports Physical Evaluations that may be performed by District volunteers, I understand the evaluation is a screening evaluation only, and that I must address all health care concerns with the Student’s personal physician or health care provider.

**PRINT NAME OF PARENT OR GUARDIAN**

**SIGNATURE OF PARENT OR GUARDIAN**

**ADDRESS**

**WORK PHONE** | **HOME PHONE**
---|---

**REGULAR PHYSICIAN’S NAME**

**OFFICE PHONE** | **OFFICE ADDRESS**:
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**PART 2 – MEDICAL EVALUATION (TO BE COMPLETED BY THE EXAMINING HEALTH CARE PROVIDER)**

This Evaluation Can Only be Performed by Medical Doctors (MDs), Doctors of Osteopathy (DOs), Physician’s Assistants (P.A.s), and Nurse Practitioners (N.P.s)

**Eyes/Ears/Nose/Throat**

**NORMAL** | **ABNORMAL (Describe)** | *(May be contained on Provider’s Form)*
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**Heart, lungs, pulmonary function**

**Abdomen, genital/hermia (males)**

**Skin and Musculoskeletal:**

- Neck/Spine/Shoulders/Back
- Arms/Hands/Fingers
- Hips/Thighs/Knees/Legs
- Feet/Ankles

**Neurologic Screening Exam (NSE)/**

**Concussion Screening Evaluation (only if needed based on above info.)**

**Recommendation:** One MUST be checked.

- Unlimited participation
- Limited participation/specífic
  - sports, events or activities
- Clearance withheld pending
  - further testing/evaluation
- No athletic participation

**Comments (use reverse of form if necessary)**

**PRINT NAME OF PHYSICIAN**

**PHYSICIAN’S SIGNATURE**

**DATE**

Original to be held on file for a period of one (1) year after the end of the Academic Year

rev 5/9/13