GLENDALE UNIFIED SCHOOL DISTRICT

PRE-PARTICIPATION PHYSICAL EVALUATION

HISTORY

Date Of Exam____________________

Name____ Sex__________ Age__________ Date of Birth____________

Grade__________ School ______________________________ Sport(s)/Activity______________________________

Address____ Phone____________________

Personal Physician ____

In case of emergency, contact: Name ____ Relationship____________________

Home phone #__________________________ Cell phone #____________________________ Work phone#____________

****Explain all "Yes" answers below, circle questions you don't know the answer to.***

Yes	No	
__	__	1. Have you had a medical illness or injury since your last checkup or sports physical?
__	__	Do you have an ongoing or chronic illness?
__	__	2. Have you ever been hospitalized overnight?
__	__	Have you ever had surgery?
__	__	3. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?
__	__	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?
__	__	4. Do you have any allergies (examples: pollen, medicine, food, or stinging insects)?
__	__	Have you ever had a rash or hives develop during or after exercise?
__	__	5. Have you ever passed out during or after exercise?
__	__	Have you ever been dizzy during or after exercise?
__	__	Have you ever had chest pain during or after exercise?
__	__	Do you get tired more quickly than your friends during exercise?
__	__	Have you ever had racing of your heart or skipped heartbeats?
__	__	Have you had high blood pressure or high cholesterol?
__	__	Have you ever been told you have a heart murmur?
__	__	Has any family member or relative died of heart problems or of sudden death before age 50?
__	__	Have you had severe viral infection (examples: myocarditis or mononucleosis) within the last month?
__	__	Has a physician ever denied or restricted our participation in sports for any heart problems?
__	__	6. Do you have any current skin problems(examples: itching, rashes, acne, warts, fungus, or blisters)?
__	__	7. Have you ever had a head injury or concussion?
__	__	Have you ever been knocked out, become unconscious, or lost your memory?
__	__	Have you ever had a seizure?
__	__	Do you have frequent or severe headaches?
__	__	Have you ever had numbness or tingling in your arms, hands, legs, or feet?
__	__	Have you ever had a stinger, burner, or pinched nerve?

Yes	No	
__	__	8. Have you ever become ill from exercising in the heat?
__	__	9. Do you cough, wheeze, or have trouble breathing during or after activity?
__	__	Do you have asthma?
__	__	Do you have seasonal allergies that require medical treatment?
__	__	10. Do you use any special protective or corrective equipment or devices that aren't usually used for your activity or position (examples: knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?
__	__	11. Have you had any problems with your eyes or vision?
__	__	Do you wear glasses, contacts, or protective eyewear?
__	__	12. Have you ever had a sprain, strain, or swelling after injury?
__	__	Have you broken or fractured any bones or dislocated any joints?
__	__	Have you had any other problems with pain or swelling in muscles, tendon, bones, or joints?

If "Yes", check all appropriate spaces and * explain below:

__Head __Neck __Back __Chest __Shoulder

__Upper Arm __Elbow __Forearm __Wrist __Hand

__Finger __Hip __Thigh __Knee __Shin/Calf

__Ankle __Foot

Yes	No	
__	__	13. Do you want to weigh more or less than you do now?
__	__	Do you lose weight regularly to meet weight requirements for your activity?
__	__	14. Do you feel "stressed out"?
		15. Record the dates of your most recent immunizations (shots) for:

Tetanus ________________ Measles________________

Hepatitis B ________________ Chickenpox ________________

Females Only:

16. When was your first menstrual period? ________________

When was your most recent menstrual period?________________

How much time do you usually have from the start of one period to the start of another? ________________________________

How many periods have you had in the last year? ________________

****Explain all "Yes" answers here:***____________________

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

____________________ __________ ____________________ __________

Signature of Parent/Guardian Date Signature of Student Date

I give permission for my son/daughter/ward to be examined by his/her own physician, or a physician associated with Glendale Healthy Kids, Glendale Memorial Hospital & Health Center, Verdugo Hills Hospital, Verdugo Hills Medical Associates, or Family Medicine Center.

____________________ __________

Signature of Parent/Guardian Date

Revised May 18, 2017