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

___	___	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

GLENDALE UNIFIED SCHOOL DISTRICT

PRE-PARTICIPATION PHYSICAL EVALUATION (continued)

PHYSICAL EXAMINATION

Name_____ Date of Birth_____

Height_____ Weight_____ %Body Fat (optional) _____ Pulse BP____/_____(_____/_____,_____/_____)

Vision: R 20/_____ L 20/_____ Corrected (check): Y ___ N ___ Pupils: Equal _____ Unequal_____

	NORMAL	ABNORMAL FINDINGS	*INITIALS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

***Station-based examination only**

CLEARANCE*:*

_____ **CLEARED**

_____ **CLEARED AFTER COMPLETING EVALUATION/REHABILITATION FOR:**

_____

_____

_____ **NOT CLEARED FOR:**_____

Reason:_____

Recommendation(s):_____

_____

Name of physician (print/type)_____ **Date**_____

Address_____ **Phone**_____

Signature of physician_____