JURUPA HILLS HIGH SCHOOL | ATHLETICS DEPARTMENT

10700 OLEANDER AVENUE, FONTANA, CA 92337 | (909) 357-6300 EXT. 16200

PHYSICAL EVALUATION FORM

(TO BE COMPLETED BY A MD., OD., OR PA-C.)

STUDENT NAME – CLEARLY PRINTED	***DATE OF BIRTH***	***AGE***

				/	/20	/20
SEX	***HEIGHT***	***WEIGHT***	***PULSE***	***B/P***	***(R) VISION***	***(L) VISION***

HAS VISION BEEN CORRECTED WITH GLASSES OR CONTACTS? **Y** or **N** | ANISOCORIA? **Y** or **N**

1. PHYSICIAN: Please ask these follow-up questions on issues that are more sensitive:

a. Do you feel stressed out or that you are under a lot of pressure?

b. Do you ever feel very sad or hopeless? Do these feelings cause you to stop doing activities that you enjoy?

c. Do you feel safe, whether at home or at school?

d. Have you ever tried smoking or do you currently smoke?

e. Have you recently tried alcohol, even if it was just one drink?

f. Have you ever taken steroids, pills or shots, without a prescription from your doctor?

2. PHYSICIAN: Please consider reviewing questions on cardiovascular symptoms or conduct extra cardiovascular screening.

Medical	**Normal**	**Musculoskeletal**	**Normal**	**Explain Abnormal Findings**
General Appearance		Neck		
Skin		Back		
Eyes/Ears/Nose/Throat		Shoulder/Upper Arms		
Hearing		Elbow/Forearms		
Lymph Nodes		Wrist/Hand/Fingers		
Heart		Hip/Buttock/Pelvis		
Pulses		Thigh		
Lungs		Knee		
Abdomen		Lower Leg		
Genitourinary *(Males Only)*		Ankle		
Neurologic Function		Foot/Toes		

☐Student athlete is cleared to participate in interscholastic sports without restriction.

☐Student athlete is cleared for sports without restriction, with recommendations for further evaluation or treatment for: ____

☐Student athlete is not cleared: (Reason) ________________________________

PHYSICIAN NAME (PRINTED)	***PHYSICIAN SIGNATURE***	***DATE***

REQUIRED

MD OFFICE STAMP

THIS COMPLETED PHYSICAL FORM IS TO BE UPLOADED TO YOUR ATHLETIC CLEARANCE ACCOUNT.

PHYSICAL MUST BE DATED AFTER MAY 1ST OF THE CURRENT SCHOOL YEAR.

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MEDICAL HISTORY FORM

(TO BE COMPLETED BY PARENT/GUARDIAN AND STUDENT, PRIOR TO THE PHYSICAL EXAMINATION)

STUDENT NAME – CLEARLY PRINTED			
DATE OF BIRTH	***AGE***	***SEX***	***GRADE***

Please list all medications and/or supplements that you are currently taking: ____________________

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Do you have allergies? ____ If yes, please specify: ☐Medicines ☐Seasonal/Pollens ☐Foods ☐Animals ☐Stinging Insects ☐Other: ____________________

	General	**Yes**	**No**
General	Has a doctor ever denied or restricted you from participating in sports?		
	Do you have an ongoing medical condition? If so, please specify below.		
	Have you ever had surgery?		
Heart Health	Have you ever passed out during or after an exercise?		
	Have you ever had shortness of breath, pain or tightness in your chest during exercise?		
	Does your heart skip beats or flutter during exercise?		
	Has your doctor ever told you that you have any heart problems? *(E.g. high blood pressure, cholesterol, murmur, etc.)*		
	Have you ever had a test such as an ECG/EKG for your heart?		
	Have you ever had an explained seizure or a seizure disorder?		
	Has a family member died of heart problems, or has had an unexpected sudden death before age 50?		
	Does anyone in your family have a heart condition, pacemaker or defibrillator?		
Musculoskeletal	Have you ever had any broken bones, dislocated joints or had a stress fracture?		
	Have you had injuries that have required an x-ray, MRI, CT scan, injection, a brace, cast, or crutches?		
	Have you had an injury to a ligament, muscle or tendon that caused you to miss a practice/game?		
	Do any of your joints become painful, swollen, feel warm, look red, or become difficult to bend?		
	Do you have a history of connective tissue disease or juvenile arthritis?		
Medical	Do you cough, wheeze or have difficulty breathing during or after exercise?		
	Is there anyone in your family that has asthma?		
	Were you born without or are you missing a kidney, testicle, spleen or other organ?		
	Do you have or have you had groin pain or a painful bulge in the groin or area?		
	Do you have rashes, skin irritations, sores or have had a staph infection or MRSA?		
	Have you ever been diagnosed with a head injury or concussion?		
	Have you had a hit to the head or body that has caused confusion, headaches, and memory or concentration problems?		
	Have you ever had numbness, tingling, or weakness in your arms/legs after being hit or falling?		
	Have you ever become ill or have gotten muscle cramps while exercising in the heat?		
	Do you or someone in your family have sickle cell trait or disease?		
	Do you have any problems with your eyes or vision or wear glasses or contact lenses?		
	Do you worry about your weight, whether with gaining or losing?		
	Are you on a special diet or do you avoid certain foods?		
	Have you ever had an eating disorder?		
	Do you have any questions/concerns that you would like to discuss with the doctor?		
Females	Have you had a menstrual period?		
	Do you feel that your periods are regular (about once a month)?		
	How old were you when you had your first menstrual period?		

Please explain "yes" answers here: ____________________

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