

Folsom High School Sports Participation Health History

Please Print

Name _____ Age _____ Male/Female (circle) Year of Graduation _____
 Address _____ City _____ Zip _____ Phone# _____

Circle the sport you are interested in playing

Football	Volleyball	Cross-Country	Cheerleading	Wrestling	Basketball
Tennis	Soccer	Skiing	Golf	Track	Softball
Baseball	Swimming				

Part A: Health History

YES NO

- | | | | |
|--|--|--------------------------|--------------------------|
| 1) Have you ever had an illness or injury that: | | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Required you to stay in the hospital? | | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Lasted longer than a week? | | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Is related to allergies? (e.g. hay fever, hives, bee sting) | | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Required an operation? | | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Is chronic? (e.g. asthma, diabetes) | | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Do you take medications or pills? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Have any members of your family under age 50 had a heart attack or died unexpectedly? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Have you ever been: | | | |
| a. Dizzy or passed out during or after exercise? | | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Unconscious or had a concussion? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Does running the ½ mile give you difficulty? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Do you: | | | |
| a. Wear glasses or contacts? | | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Wear dental bridges, plates, or braces? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Have you ever had a heart murmur, high blood pressure, or a heart abnormality? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Do you have any allergies to medicines? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) Are you missing a kidney, lung, eye, or testicle? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 10) Have you ever had severe arm or neck pain? | | <input type="checkbox"/> | <input type="checkbox"/> |

Explain any "YES" answers here: _____

11) What is the date (year) of your last tetanus booster? _____ ****REQUIRED INFORMATION****

- 12) Have you sprained, strained, dislocated or broken any of the following:
- | | | | | | |
|---------|-------|------------|----------|------------|-------|
| Neck | Back | Collarbone | Shoulder | Humerus | Elbow |
| Forearm | Wrist | Hand | Pelvis | Hip | Thigh |
| Knee | Leg | Ankle | Foot | Chest/Ribs | |

I hereby state the answers on this form are correct to the best of my knowledge.

Signature of athlete _____ *Date:* _____

I agree with the history and give my permission for an examination.

Parent Signature: _____ *Date:* _____

Folsom High School

Sports Participation Health History

Students Name: _____

Part B: Physical Exam Record (to be filled out by Physician)

PHYSICAL EXAMINATION RECORD

Height _____ inches

Vision: right _____

Weight _____ pounds

left _____

BP _____ / _____

Pulse _____

CORE EXAMINATION	NORMAL	ABNORMAL FINDINGS	INITIALS
a) Eyes _____			
b) Ears, nose throat _____			
c) Mouth, teeth _____			
d) Neck _____			
e) Cardiovascular _____			
f) Chest, lungs _____			
g) Abdomen _____			
h) Skin _____			
i) Genitalia, hernia _____			

ORTHOPEDIC EXAMINATION	NORMAL	ABNORMAL FINDINGS	INITIALS
a) Neck _____			
b) Spine _____			
c) Shoulders _____			
d) Arms, elbows _____			
e) Forearm, wrists, hands _____			
f) Hips, thighs _____			
g) Knees, legs _____			
h) Ankle, feet _____			
i) Flexibility _____			

Abnormalities found in the history and physical that need further assessment:

RECOMMENDATIONS

- Approved for full participation
- Needs to have the above abnormalities cleared before participation.
- Disqualified or limited in the following sports: _____

Physicians Signature: _____ **Date** _____

**Folsom Cordova Unified School District
Folsom High School Athletic Physical Form**

Name _____ Grade _____ Birth Date _____
Sex: M F

Legal Name (if different from above) _____

Address: _____

Home Phone: _____ Emergency Phone: _____

Name of _____ Business Phone: _____

Father Stepfather Guardian (Circle one)

Cell Phone: _____

Name of _____ Business Phone _____

Mother Stepmother Guardian (Circle one)

Cell Phone _____

Student Health Concerns _____ Allergies _____

Long Term Medication: _____

To Parent or Guardian: All students participating in interscholastic events must have a medical physical, proof of insurance coverage, and parental permission for participation and emergency care.

1. **Physician's Statement:** I hereby certify that this student was examined by me and found physically fit to engage in athletic contests during the _____ - _____ school year.

Physician's Signature **Date**

2. Parent Permission:

a. **Emergency Care:** In case of an accident or sudden illness, when a parent or guardian is unavailable, I authorize a school representative to obtain medical care for my child, including necessary transportation in accordance with their best judgment. I agree to pay all costs incurred as a result of the foregoing.

b. **Insurance Coverage:** The insurance coverage required by the Education Code includes insurance protection for medical and hospital expenses resulting from accidental bodily injury in an amount of at least \$1,500.00 for all such services. I declare that my son/daughter is insured in accordance with the Education Code through the following insurance company:

Name of Insurance **Company Policy Number**

I declare that I will maintain this insurance and will notify, in writing, if the policy is cancelled or is in default.

c. **Activity Permission:** I give my consent for my son/daughter to compete in sports and go on away trips with school representatives. *Nature of Activity:* Athletic Contests *Date of Activity, Time of Departure & Return, Destination:* As Scheduled *Means of Transportation:* District owned vehicle or Faculty owned vehicle.

Signature of Parent or Guardian **Date**

Please indicate activities in which student will participate:

1. _____ 2. _____ 3. _____