



Fremont Union High School District

Physical Exam Form – Part: Student/Athlete's Health History (Required)

Student ID _____

School:	School Year:	Sport/Activities Trying out for:		
Last Name:	First Name:	M.I.:		
Grade:	Home Phone:	Date of Birth:	Age:	Gender:
Home Address:		City:	Zip:	
Name of Family Doctor or Medical Clinic/ Hospital:				
Street Address of Family Doctor or Medical Clinic/ Hospital:				
City:	Zip:	Doctor's Office Phone Number:		

STUDENT'S HEALTH HISTORY: To be completed by the Parent/Guardian and reviewed by the doctor at time of the student's Physical Exam. Parents, please check (¥) "Yes" or "No" to the questions below about your child's health history.

Date of student's last Diphtheria/Tetanus shot? (month/day/year)

Has the student had any:	Yes	No
1. Chronic or recurrent illness?	<input type="checkbox"/>	<input type="checkbox"/>
2. Illness lasting over 1 week?	<input type="checkbox"/>	<input type="checkbox"/>
3. Hospitalization?	<input type="checkbox"/>	<input type="checkbox"/>
4. Surgery other than removal of tonsils?	<input type="checkbox"/>	<input type="checkbox"/>
5. Missing organs (eye, kidney, testicle)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Problems with heart or shortness of breath during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7. Dizziness or fainting with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
8. Fainting, bad headaches, or convulsions?	<input type="checkbox"/>	<input type="checkbox"/>
9. Concussion or loss of consciousness?	<input type="checkbox"/>	<input type="checkbox"/>
10. Heat exhaustion, heatstroke, or other problems with heat?	<input type="checkbox"/>	<input type="checkbox"/>
Does this student:		
11. Wear eyeglasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
12. Wear dental bridges, braces, or plates?	<input type="checkbox"/>	<input type="checkbox"/>
13. Take any medications? If so, please list them below.	<input type="checkbox"/>	<input type="checkbox"/>

Is there any history of:	Yes	No
14. Injuries requiring Doctor's treatments?	<input type="checkbox"/>	<input type="checkbox"/>
15. Neck or back injury?	<input type="checkbox"/>	<input type="checkbox"/>
16. Knee injury?	<input type="checkbox"/>	<input type="checkbox"/>
17. Shoulder or elbow injury?	<input type="checkbox"/>	<input type="checkbox"/>
18. Ankle injury?	<input type="checkbox"/>	<input type="checkbox"/>
19. Other serious joint injury?	<input type="checkbox"/>	<input type="checkbox"/>
20. Broken bones or fractures?	<input type="checkbox"/>	<input type="checkbox"/>
21. Other serious injury?	<input type="checkbox"/>	<input type="checkbox"/>
Further History:		
22. Is there any reason why this student should NOT participate in sports?	<input type="checkbox"/>	<input type="checkbox"/>
23. Has any family member died suddenly at less than 40 years of age of causes other than an accident?	<input type="checkbox"/>	<input type="checkbox"/>
24. Has any family member had a heart attack at less than 35 years of age?	<input type="checkbox"/>	<input type="checkbox"/>

Use the space below to explain any questions above that you answered "yes" to:

Medications your son/daughter is currently taking:

Parent's/Guardian's & Student's Acknowledgement

I have reviewed and agree with the information presented on this form. I also understand that the Physical Examination is primarily for sports participation screening and is not intended to replace the routine health care visits as recommended by the student's personal doctor. I do not know of any reason why the above-named student should not participate and represent his/her school in supervised athletic activities.

Signature of Parent/Guardian:

Date (mo/day/year):

Signature of Student/Athlete:

Date (mo/day/year):



A doctor must administer this Physical Exam & sign/date below.

Fremont Union High School District Physical Exam Form - Part 2 (Required)

Sport/
Activity:

Student ID _____

Parents - Please complete the top line for the doctor and please print neatly. All other areas will be completed by the doctor.

Last Name: _____ First Name: _____ M.I.: _____ DOB _____ School: _____

Height: _____ Weight: _____ % Body Fat (optional) _____ Pulse: _____ BP: _____ (____/____, ____/____)

Vision: R - 20/ _____ L - 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

Follow-up Questions on More Sensitive Issues - Questions asked by the doctor	Yes	No
1. Do you feel stressed out or under a lot of pressure?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you feel safe?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever tried cigarette smoking, even 1 or 2 puffs?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you currently smoke?	<input type="checkbox"/>	<input type="checkbox"/>
6. During the past 30 days, have you used chewing tobacco, snuff, or dip?	<input type="checkbox"/>	<input type="checkbox"/>
7. During the past 30 days, have you had at least one drink of alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever taken steroid pills or shots without a doctor's prescription?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever taken any supplements to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>
Does this student:		
10. Wear eyeglasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
11. Wear dental bridges, braces, or plates?	<input type="checkbox"/>	<input type="checkbox"/>
12. Take any medications? If so, please list them below.	<input type="checkbox"/>	<input type="checkbox"/>

Does this student:

Dr.'s Notes: _____

DOCTOR'S EXAMINATION	NORMAL	ABNORMAL FINDINGS (Doctor, please list & describe any abnormalities)
Appearance		
Eyes/ears/nose/throat		
Hearing		
Lymph Nodes		
Heart		
Murmurs		
Pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hips/thigh		
Knee		
Leg/ankle		
Foot/toes		

Multiple-examiner set-up only. **Having a third party present is recommended for the genitourinary examination.

DOCTOR'S CLEARANCE: This student is medically cleared to participate in sports/activities: YES _____ NO _____ (Doctor checks one)

Exceptions or limitations (if any): _____

Doctor's Printed Name & Address: _____
(Stamp is okay)

Doctor's Signature: _____ Date: _____
M.D.? Yes No Doctor's I.D. #: _____