FRESNO UNIFIED SCHOOL DISTRICT
Pre-Participation Health Evaluation Record for Sports

PARENT
FILL OUT

SPORT_____

Last_____First_____Middle_____Student ID#_____

School_____Grade_____Birthdate_____Male/Female_____

**PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE**

I hereby give my consent for the above-named student to represent his or her school in competitive sports except those indicated on this form by the examining physician. I also give my consent for the student to accompany the school team on any of its local or out-of-town trips. The Fresno Unified School District Board of Education has no responsibility to provide first aid at any of the games and the parent or guardian understands that the student and parent assume the risk of injury when they sign this form. However, in the event physicians, physical therapists, physicians assistants, nurses, or other persons trained in the rendering of first aid are available, as volunteers or otherwise, and render aid to any student injured during the course of any such activities or travel, then the parents do hereby release and forever discharge such persons and the Fresno Unified School District Board of Education from any liability arising out of and first aid or immediate treatment of injuries.

An athletic physical arranged by the school district is not a complete physical examination. It is a screening to detect obvious impairments that might affect the student's safety in sports participation. This evaluation should not be used as a substitute for regular health maintenance examinations with your personnel physician.

Printed Name of Parent/Guardian_____ Signature_____

Address_____City, Zip_____ Phone Number_____ Date_____

**PLEASE CIRCLE YES OR NO FOR THE FOLLOWING QUESTIONS:**

| | | |
|---|---|---|
| 1. | YES / NO | Chronic or recurrent illness? (Asthma, diabetes, hepatitis, kidney disease, mononucleosis, tuberculosis, rheumatic fever) |
| 2. | YES / NO | Hospitalization? |
| 3. | YES / NO | Surgery other than tonsillectomy? |
| 4. | YES / NO | Missing organs (eye, kidney, testicle?) |
| 5. | YES / NO | Allergy to any medications? |
| 6. | YES / NO | Problems with heart, heart murmur, or blood pressure? |
| 7. | YES / NO | Chest pain with exercise? |
| 8. | YES / NO | Dizziness or fainting with exercise? |
| 9. | YES / NO | Dizziness, fainting, frequent headaches, or convulsions? |
| 10. | YES / NO | Concussion or unconscious? |
| 11. | YES / NO | Heat exhaustion, heatstroke, or other problems with heart? |
| 12. | YES / NO | Skin problems? |
| 13. | YES / NO | Does this student wear eyeglasses contacts? |
| 14. | YES / NO | Does this student wear a hearing aid? |
| 15. | YES / NO | Does this student wear dental bridges, braces, plates? |
| 16. | YES / NO | Does this student take medication on a routine or daily basis? Use inhaler? |

**IS THERE ANY HISTORY OF**

| | | |
|---|---|---|
| 17. | YES / NO | Injuries requiring MD treatment? |
| 18. | YES / NO | Neck injury? |
| 19. | YES / NO | Knee injury? |
| 20. | YES / NO | Ankle injury? |
| 21. | YES / NO | Other serious joint injury? Dislocations? |
| 22. | YES / NO | Broken bones (fractures)? Serious sprains? |
| 23. | YES / NO | Use any special pads or braces? |

**FOR FEMALES:**

At what age did you experience your first menstrual period? _____ In the last year, what is the longest time you have gone between periods? _____?

DOCTOR OFFICE FILL OUT/

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SPORT_____

Last_____First_____Middle_____Student ID#_____

School_____Grade_____Birthdate_____Male/Female_____

| | | | | | |
|---|---|---|---|---|---|
| 24. | YES / NO | Is there any reason why this student should not participate in sports? | 26. | YES / NO | Has any family member had a heart attack at less than 55 years of age? |
| 25. | YES / NO | Has any family member died suddenly at less than 40 years of age? | | | |

Use the space below to provide any additional information or explanation of the above numbered questions.

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Date of last tetanus shot _____ Current family physician _____

Height_____ Weight_____ Vision Right _____ /_____ Normal without corrective lens
Vision Left _____/ _____With corrective lens

Pulse Rate _____ After exercise _____ Recovery rate satisfactory? YES / NO

Blood Pressure _____/_____ Percent of body fat _____

| | Normal | Abnormal | Comments |
|---|---|---|---|
| Heart | | | |
| Pulses | | | |
| Lunge | | | |
| Abdomen | | | |
| Neck | | | |
| Shoulders | | | |
| Elbows | | | |
| Wrists | | | |
| Hands | | | |
| Back | | | |
| Knees | | | |
| Ankles | | | |
| Feet | | | |
| Other physical exam pertinent to historical information | | | |

**PARTICIPATION RECOMMENDATIONS:**

_____ No history of physical finding on this exam would prohibit this student from participating in competitive sports.
_____ This student should have the following health problems evaluated or treated before participation recommendations can be made. _____
_____ This student has health problems that prohibit him/her from participating in the following competitive sports:
_____/_____/_____
_____ Recommend follow-up by school nurse.

**Physicians Name (print) _____Physicians Signature _____**

**State License Number _____Address _____**

**Phone _____ Date of examination _____**