Student ID #:_____ Sport(s): _____

Fontana Unified School District Preparticipation Physical Evaluation

Part 1 – Physical Examination Form (To be completed by a Medical Doctor (MD), Osteopathic Physician (DO), or Physician's Assistant (PA-C))

Name: _____ Birthdate: _____ Age: _____

Gender: _____ Height: _____ Weight: _____ Pulse: _____ Pulse: _____/_____

Vision: R_____/20 L_____/20 Corrected with glasses or contacts: Y N Anisocoria: Y N

1. Physician: Please ask these follow-up questions on more sensitive issues.
   a. Do you feel stressed out or that you are under a lot of pressure?
   b. Do you ever feel sad, hopeless, depressed, or anxious?
   c. Do you feel safe whether at home or school?
   d. Have you ever tried or currently use tobacco products (cigarettes, chewing tobacco, vape)?
   e. Do you drink alcohol or use other drugs?
   f. Have you ever taken performance-enhancing drugs without a doctor's prescription?
2. Physician: please consider reviewing questions on cardiovascular symptoms (see Questions 4-13 attached Medical History form).

Has the student ever been diagnosed with COVID-19?				**YES**	**NO**
Has the student been diagnosed with COVID-19 within the past 3 months?				**YES**	**NO**
Please describe the level of COVID-19 symptoms experienced:		**N/A**	**ASYMPTOMATIC**	**MILD/MODERATE**	**SEVERE (Hospitalization)**
	MEDICAL	WITHIN NORMAL LIMITS	ABNORMAL FINDINGS		
1	General Appearance				
2	Skin				
3	Eyes/Ears/Nose/Throat				
4	Hearing				
5	Lymph Nodes				
6	Heart				
7	Pulse				
8	Lungs				
9	Abdomen				
10	Genitourinary (males only)				
11	Neurological Function				
	MUSCULOSKELETAL	WITHIN NORMAL LIMITS	ABNORMAL FINDINGS		
12	Neck				
13	Back				
14	Shoulder/Upper Arm				
15	Elbow/Forearm				
16	Wrist/Hands/Fingers				
17	Hip/Buttocks/Pelvis				
18	Thigh				
19	Knee				
20	Lower Leg				
21	Ankle				
22	Foot/Toes				
23	Overall Functional Movement				

☐ Student-Athlete is **CLEARED** to participate in interscholastic sports without restriction.

☐ Student-Athlete is **CLEARED** for sports without restrictions with **recommendations for further evaluation and treatment for**:

_____

☐ Student-Athlete is **NOT CLEARED** for sports:
Reasons and/or recommendations for denial of clearance:

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of Physician:_____ Date: _____

Physician Signature and Stamp: _____

Student ID #:_____

Fontana Unified School District Preparticipation Physical Evaluation

Part 2 – Medical History Form (To be completed by parent/guardian and student prior to receiving Physical Examination)

Name: _____ Date of Exam:_____ Birthdate: _____ Age: _____ Gender: _____ Grade: _____

Medicines currently using: List all current prescriptions, over-the-counter medications, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies: ☐ Seasonal/pollen ☐ Food(s) ☐ Animals ☐ Stinging Insects
☐ Other: _____

	GENERAL HISTORY	YES	NO	EXPLAIN
1	Has a doctor ever denied or restricted you from participating in sports?			
2	Do you have any ongoing medical conditions? If so, please specify below.			
3	Have you ever had surgery?			
	HEART HEALTH (ATHLETE)	YES	NO	
4	Have you ever passed out or nearly passed out during or after exercise?			
5	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			
6	Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?			
7	Has a doctor ever told you that you have any heart problems?			
8	Has a doctor ever requested a test for your heart? For example, ECG or EKG.			
9	Do you get light-headed or feel shorter of breath than your friends during exercise?			
10	Have you ever had a seizure?			
	HEART HEALTH (FAMILY)	YES	NO	
11	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			
12	Does anyone in your family have a genetic heart problem?			
13	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			
	BONE AND JOINT	YES	NO	
14	Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?			
15	Do you have a bone, muscle, ligament, or joint injury that bothers you?			
	MEDICAL QUESTIONS	YES	NO	
16	Do you cough, wheeze, or have difficulty breathing during or after exercise?			
17	Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?			
18	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?			
19	Do you have any recurring skin rashes or rashes that come and go, including herpes or MRSA?			
20	Have you ever had a hit to the head or the body that has caused confusion, headaches, memory, or concentration problems?			
21	Have you ever had numbness, tingling, or weakness in your arms/legs after being hit or falling?			
22	Have you ever become ill while exercising in the heat?			
23	Do you or does someone in your family have sickle cell trait or disease?			
24	Have you ever had or do you have any problems with your eyes or vision?			
25	Do you worry about your weight?			
26	Are you trying to or has anyone recommended that you gain or lose weight?			
27	Are you on a special diet or do you avoid certain types of foods or food groups?			
28	Have you ever had an eating disorder?			
	FEMALES ONLY	YES	NO	
29	Have you ever had a menstrual period?			
30	Do you feel your periods are regular (about once per month)?			
31	How old were you when you had your first menstrual period?	Age:		

Please explain any "YES" answers here that could not fit above:

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

_____ _____ _____

Student-Athlete Signature **Parent Signature** **Date**