

Preparticipation Physical Questionnaire

History

Must be completed by Parent/Guardian before examination to the best of your knowledge

Name _____ Sex _____ Age _____ Date of Birth _____	
Grade _____	School _____ Sport(s) _____
Address _____	
Personal Physician _____	
<i>In case of emergency, contact</i>	
Name _____	Relationship _____ Phone (H) _____ (W) _____

This section is to be carefully completed by the student and his/her parent (s) or legal guardian (s) before participation in interscholastic athletics in order to help detect possible risks.

I hereby give my permission for my son/daughter to participate in competitive athletics and go with a representative of the school on any trips. In case this pupil is injured, you are authorized to have him/her treated. I will assume the financial responsibility.

Parent/Guardian Signature

HISTORY (Complete before submitting to the doctor)

Explain "YES" answers in the space provided. Circle questions you don't know the answer to.

- | | | | | | | | | | | | | | | | | |
|--|-------|------------|------------|-----------|-------|---------|-------|------------|------------|-----|-------|------|-----------|-------|-----------|---|
| <ol style="list-style-type: none"> 1. Has a doctor ever denied or restricted your participation in sports for any reason. Yes No
<input type="checkbox"/> <input type="checkbox"/> 2. Do you have an ongoing medical condition (like diabetes or asthma)? <input type="checkbox"/> <input type="checkbox"/> 3. Are you currently taking any prescription or nonprescription (Over-the-counter) medicines or pills? <input type="checkbox"/> <input type="checkbox"/> 4. Do you have allergies to medicines, pollens, foods, or stinging insects? <input type="checkbox"/> <input type="checkbox"/> 5. Do you think you are in good health? <input type="checkbox"/> <input type="checkbox"/> 6. Have you ever passed out or nearly passed out DURING exercise? <input type="checkbox"/> <input type="checkbox"/> 7. Have you ever passed out or nearly passed out AFTER exercise? <input type="checkbox"/> <input type="checkbox"/> 8. Have you ever had discomfort, pain, or pressure in your chest during exercise? <input type="checkbox"/> <input type="checkbox"/> 9. Does your heart race or skip beats during exercise? <input type="checkbox"/> <input type="checkbox"/> 10. Has a doctor ever told you that you have (check all that apply)
High Blood Pressure A heart infection
High Cholesterol A heart murmur 11. Has a doctor ever ordered a test for your heart? (example, ECG, echocardiogram) <input type="checkbox"/> <input type="checkbox"/> 12. Has anyone in your family died for no apparent reason? <input type="checkbox"/> <input type="checkbox"/> 13. Does anyone in your family have a heart problem? <input type="checkbox"/> <input type="checkbox"/> 14. Has any family member or relative died of heart problems or sudden death before age 50? <input type="checkbox"/> <input type="checkbox"/> 15. Have you ever spent the night in a hospital for yourself? <input type="checkbox"/> <input type="checkbox"/> 16. Have you ever had surgery? <input type="checkbox"/> <input type="checkbox"/> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <p>17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis that caused you to miss a practice or game? If yes, circle below:</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td>Head</td><td>Neck</td><td>Shoulder</td><td>Upper Arm</td><td>Elbow</td></tr> <tr> <td>Forearm</td><td>Chest</td><td>Upper back</td><td>Lower back</td><td>Hip</td></tr> <tr> <td>Thigh</td><td>Knee</td><td>Calf/Shin</td><td>Ankle</td><td>Foot/Toes</td></tr> </table> </div> <ol style="list-style-type: none"> 18. Have you ever had any broken or fractured bones or dislocated joints? If yes, circle below <input type="checkbox"/> <input type="checkbox"/> 19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: <input type="checkbox"/> <input type="checkbox"/> <ol style="list-style-type: none"> 20. Have you ever had a stress fracture? <input type="checkbox"/> <input type="checkbox"/> 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? <input type="checkbox"/> <input type="checkbox"/> 22. Has a doctor ever told you have asthma or allergies? <input type="checkbox"/> <input type="checkbox"/> | Head | Neck | Shoulder | Upper Arm | Elbow | Forearm | Chest | Upper back | Lower back | Hip | Thigh | Knee | Calf/Shin | Ankle | Foot/Toes | <ol style="list-style-type: none"> 23. Do you cough, wheeze, or have difficulty breathing during or after exercise? Yes No
<input type="checkbox"/> <input type="checkbox"/> 24. Is there anyone in your family who has asthma? <input type="checkbox"/> <input type="checkbox"/> 25. Have you ever used an inhaler or taken asthma medicine? <input type="checkbox"/> <input type="checkbox"/> 26. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? <input type="checkbox"/> <input type="checkbox"/> 27. Have you ever had a head injury or concussion? <input type="checkbox"/> <input type="checkbox"/> 28. Have you been hit in the head and been confused or lost your memory? <input type="checkbox"/> <input type="checkbox"/> 29. Have you ever had a seizure? <input type="checkbox"/> <input type="checkbox"/> 30. Do you have headaches with exercise? <input type="checkbox"/> <input type="checkbox"/> 31. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? <input type="checkbox"/> <input type="checkbox"/> 32. Have you ever been unable to move your arms or legs after being hit or falling? <input type="checkbox"/> <input type="checkbox"/> 33. When exercising in the heat do you have severe muscle cramps or become ill? <input type="checkbox"/> <input type="checkbox"/> 34. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? <input type="checkbox"/> <input type="checkbox"/> 35. Do you wear glasses or contacts? <input type="checkbox"/> <input type="checkbox"/> 36. Do you have concerns that you would like to discuss with a doctor? <input type="checkbox"/> <input type="checkbox"/> 37. Record the dates of your most recent immunizations (shots)
Tdap _____
"Booster" Shot for tetanus _____
Hepatitis B _____ Measles _____ <p>FEMALES ONLY</p> <ol style="list-style-type: none"> 38. The date of your last menstrual period? _____ 39. How old were you when you had your first menstrual period? _____ <p>Explain "Yes" Answers Here: (Attach additional sheets as needed)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> |
| Head | Neck | Shoulder | Upper Arm | Elbow | | | | | | | | | | | | |
| Forearm | Chest | Upper back | Lower back | Hip | | | | | | | | | | | | |
| Thigh | Knee | Calf/Shin | Ankle | Foot/Toes | | | | | | | | | | | | |

I (we) hereby state, to the best of my (our) knowledge, my (our) answers to the above questions are complete and correct.

Athlete Signature: _____ Parent/Guardian Signature: _____ Date _____

*****This student has family insurance Yes No

If yes, medical insurance company name and policy number _____

Note: History and all consent forms must be completed prior to physical examination

Name _____ Date of Birth _____
 Height _____ Weight _____ % Body fat (optional) _____ Pulse _____
 BP _____ / _____ (_____ / _____ , _____ / _____) Vision R 20/ _____ L 20/ _____ Corrected Y N
 Pupils: Equal _____ Unequal _____

MEDICAL	Normal	Abnormal Findings
Appearance		
Eyes/Ears/Nose/Throat		
Hearing		
Lymph Nodes		
Heart		
Murmurs		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/Forearm		
Wrist/hand/fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

PHYSICIAN CLEARANCE

Name of Physician (print) _____ Date _____

Address _____ Phone _____

Signature of Physician _____, MD, DC or DO

Medical License No. or Stamp _____



Cleared for Athletic Participation YES NO (IF NO FILL-OUT BELOW)

Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reasons: _____

2020-2021 | INTERSCHOLASTIC ATHLETIC INSURANCE COVERAGE CERTIFICATION

Dear Parent or Guardian:

Before your son or daughter is eligible to participate in interscholastic athletics, insurance coverage for medical, hospital, and dental expenses resulting from accidental bodily injury in an amount of at least \$1,500.00 for all services is required according to the Education Code Sections 32220 and 32221 and must be obtained by you for the student who expects to participate. Please read carefully the following affidavit, and if, and only if, you presently have the required coverage for your child, sign the affidavit.

AFFIDAVIT

I, _____, parent or guardian (Name of Parent or Guardian)

of _____, do hereby declare that he/she is insured (Name of Student)

in accordance with Education Code Sections 32220 and 32221, through:

MY OWN INSURANCE:

(Health Insurance Company Name - \$1500.00 Minimum)

OR

I WISH TO PURCHASE:

(indicate with check mark and get brochure from the Athletic Director):

- 1. MYERS-STEVENS & TOOHEY & CO., Athletic Coverage (Coverage in season of sport only. Please send the brochure with payment to the school and make checks payable to Myers-Stevens and Toohey & Co., Inc.)

Table with 2 columns: Interscholastic tackle football options and PLEASE CHECK amounts. Includes Low, Mid, and High options with prices ranging from \$235.00 to \$339.00.

All Sports except tackle football (see #2 below)

- 2. MYERS-STEVENS & TOOHEY & CO., Inc. – Student Accident Insurance (Includes regular student accident medical/hospital/dental benefits for all sports, except does not provide coverage for tackle football, for grades 9 through 12. Please send the payment to the school and make check payable to Myers-Stevens and Toohey & Co., Inc.)

Table with 3 columns: 7th through 12 grades options, School Time, and 24-Hour. Includes Low, Mid, and High options with prices ranging from \$16.00 to \$328.00.

I understand that the aforesaid law requires that the above coverage apply to members of athletic teams and non-competitors who perform duties in connection with inter-school athletic events while such persons are engaged in or preparing for an athletic event promoted under the sponsorship or arrangement of the school district or student body association to or from or other place of instruction and the place of the athletic event.

I declare that I will maintain this insurance and will notify, in writing, the principal of the appropriate school immediately if the policy is canceled or is in default.

I declare under penalty of perjury the foregoing is true and correct.

(Signature of Parent or Guardian)

(Date)