Preparticipation Physical Questionnaire

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_____
In case of emergency, contact
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.

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason.	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma?	☐	☐
3. Are you currently taking any prescription or nonprescription (Over-the-counter) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Do you think you are in good health?	☐	☐
6. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
7. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
8. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
9. Does your heart race or skip beats during exercise?	☐	☐
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, echocardiagram)	☐	☐
12. Has anyone in your family died for no apparent reason?	☐	☐
13. Does anyone in your family have a heart problem?	☐	☐
14. Has any family member or relative died of heart problems or sudden death before age 50?	☐	☐
15. Have you ever spent the night in a hospital for yourself?	☐	☐
16. Have you ever had surgery?	☐	☐
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:	☐	☐
18. Have you ever had any broken or fractured bones or dislocated joints? If yes, circle below	☐	☐
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:	☐	☐
20. Have you ever had a stress fracture?	☐	☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22. Has a doctor ever told you have asthma or allergies?	☐	☐

Head	Neck	Shoulder	Upper Arm	Elbow
Forearm	Chest	Upper back	Lower back	Hip
Thigh	Knee	Calf/Shin	Ankle	Foot/Toes

	Yes	No
23. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
24. Is there anyone in your family who has asthma?	☐	☐
25. Have you ever used an inhaler or taken asthma medicine?	☐	☐
26. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
27. Have you ever had a head injury or concussion?	☐	☐
28. Have you been hit in the head and been confused or lost your memory?	☐	☐
29. Have you ever had a seizure?	☐	☐
30. Do you have headaches with exercise?	☐	☐
31. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
32. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
33. When exercising in the heat do you have severe muscle cramps or become ill?	☐	☐
34. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
35. Do you wear glasses or contacts?	☐	☐
36. Do you have concerns that you would like to discuss with a doctor?	☐	☐

37. Record the dates of your most recent immunizations (shots)
Tdap_____
"Booster" Shot for tetanus_____
Hepatitis B_____ Measles_____

FEMALES ONLY

38. The date of your last menstrual period? _____
39. How old were you when you had your first menstrual period? _____

Explain "Yes" Answers Here: (Attach additional sheets as needed)

_____
_____
_____
_____
_____
_____

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

PHYSICAL EXAMINATION FORM

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:_____

SAN BERNARDINO CITY UNIFIED SCHOOL DISTRICT

2018-2019 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.)

Interscholastic tackle football	PLEASE CHECK
Low Option	$235.00
□ Mid Option	$295.00
□ High Option	$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.)

7th through 12 grades	School Time	24-Hour
Low Option	$53.00 □	$225.00 □
Mid Option	$68.00 □	$276.00 □
High Option	$79.00 □	$328.00 □
Dental	$16.00 □	

I understand that the aforesaid law requires that the above coverage apply to members of athletic teams and non-competitors who preform 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)