Fall Sport_____
Winter Sport_____
Spring sport_____

Delano Joint Union High School District Athletic Physical Form

Student's Name: _____ **ID#**_____ **AGE:** _____ **DATE OF BIRTH:** _____

PHONE: _____ **ADDRESS:** _____ **CITY:** _____ **ZIP:** _____

HEALTH HISTORY (PLEASE CHECK APPROPERIATE BOX)

Chronic/Recurrent/Illness	YES ☐	NO ☐	Chronic Headaches	YES ☐	NO ☐
Surgeries other than tonsils	YES ☐	NO ☐	Chest Pain	YES ☐	NO ☐
Injuries treated by Physician	YES ☐	NO ☐	Problems with blood	YES ☐	NO ☐
Under care of Physician	YES ☐	NO ☐	Problems with liver, spleen, kidneys	YES ☐	NO ☐
Currently taking medication	YES ☐	NO ☐	Hernia	YES ☐	NO ☐
Dizziness, Fainting	YES ☐	NO ☐	Bone/Joint injury	YES ☐	NO ☐
Concussions	YES ☐	NO ☐	Allergy to medication	YES ☐	NO ☐

PLEASE EXPLAIN THE "YES" ANSWERS: _____

Parent Signature stating Health History is current: _____

Relevant Medical Information for Coaches and Athletic Department:

Allergies: _____ **EpiPen Necessary:** YES ☐ NO ☐

Asthma: YES ☐ NO ☐ **EMERGENCY Medication:** _____

Diabetes: YES ☐ NO ☐ **Emergency Medication:** _____

Seizure Disorder: YES ☐ NO ☐ **Emergency Medication:** _____

PHYSICAL EVALUATION

HT_____ **WT**_____ **BP**_____ **PULSE**_____

GENERAL: _____

CHEST: _____**HEART:**_____

ABDOMEN: _____**GU/HERNIA:** _____

NECK/BACK: _____

This Athlete is: **Cleared for all sports without restrictions** YES ☐ NO ☐

Cleared for all sports <u>with restrictions:</u> YES ☐ NO ☐

LIST RESTRICTIONS/LIMITATIONS: _____

If athlete is <u>NOT</u> cleared for sport(s) please explain:

Reason and Recommendation's: _____

SUMMARY/COMMENTS: _____

Physician's Office Stamp:

I have examined the above-named student and completed the pre-participation evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (parents/Guardian)

NAME OF PRACTIONER (PRINT/TYPE):_____**ADDRESS**_____

PRACTITIONER LICENSENS#_____**PRACTITIONER PHONE#:**_____

SIGNATURE OF PRACTIONER: _____**, MD OR DO DATE OF EXAM:** _____

Fall Sport_____
Winter Sport_____
Spring sport_____

Delano Joint Union High School District Forma Física Atlética

Nombre del Estudiante: _____ **ID#**_____ **EDAD:** _____ **FECHA DE NACIMIENTO:** _____

TELEFONO: _____ **DOMICILIO:** _____ **CIUDAD:** _____ **CODIGO POSTAL:** _____

HISTORIAL DE SALUD (FAVOR DE MARCAR EL CUADRO APROPIADO)

Enfermedad/Crónica/Recurrente	**SI** ☐	**NO** ☐	**Dolor de Cabeza Crónico**	**SI** ☐	**NO** ☐
Cirugías aparte de las anginas	**SI** ☐	**NO** ☐	**Dolor de Pecho**	**SI** ☐	**NO** ☐
Lastimaduras tratadas por un Médico	**SI** ☐	**NO** ☐	**Problemas con la sangre**	**SI** ☐	**NO** ☐
Bajo Cuidado Médico	**SI** ☐	**NO** ☐	**Problemas con el hígado, bazo, riñones**	**SI** ☐	**NO** ☐
Actualmente tomando medicamento	**SI** ☐	**NO** ☐	**Hernia**	**SI** ☐	**NO** ☐
Mareos, Desmayos	**Si** ☐	**NO** ☐	**Lastimadura de Hueso/Coyuntura**	**SI** ☐	**NO** ☐
Conmociones	**SI** ☐	**NO** ☐	**Alergia a medicamento**	**SI** ☐	**NO** ☐

FAVOR DE EXPLCAR LAS RESPUESTAS "SI": _____

Firma de Padres indicando que el historial esta al corriente: _____

Información Medica Relevante para los Entrenadores y el Departamento Atlético:

Alergias: _____ **EpiPen Necesaria:** **SI** ☐ **NO** ☐

Asma: **SI** ☐ **NO** ☐ **Medicamento de EMERGENCIA:** _____

Diabetes: **SI** ☐ **NO** ☐ **Medicamento de EMERGENCIA:** _____

Trastorno Convulsivo: **SI** ☐ **NO** ☐ **Medicamento de EMERGENCIA:** _____

EVALUACION FISICA

HT_____ **WT**_____ **BP**_____ **PULSE**_____

GENERAL: _____

CHEST: _____**HEART:**_____

ABDOMEN: _____**GU/HERNIA:** _____

NECK/BACK: _____

This Athlete is: **Cleared for all sports without restrictions** **YES** ☐ **NO** ☐

Cleared for all sports <u>with restrictions:</u> **YES** ☐ **NO** ☐

LIST RESTRICTIONS/LIMITATIONS: _____

If athlete is <u>NOT</u> cleared for sport(s) please explain:

Reason and Recommendation's: _____

SUMMARY/COMMENTS: _____

Physician's Office Stamp:

I have examined the above-named student and completed the pre-participation evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (parents/Guardian)

NAME OF PRACTIONER (PRINT/TYPE):_____**ADDRESS**_____

PRACTITIONER LICENSENS#_____**PRACTITIONER PHONE#:**_____

SIGNATURE OF PRACTIONER: _____**, MD OR DO DATE OF EXAM:** _____