RIALTO UNIFIED SCHOOL DISTRICT
DEPARTMENT OF HEALTH SERVICES
SECONDARY SPORTS PHYSICAL EXAMINATION

Name: _____ **Age:** _____ **Sex:** _____ **DOB:** _____

Address: _____ **Telephone:** _____

School: _____ **Grade:** _____ **Sport(s):** _____

Personal Physician: _____ **Physician's Telephone:** _____

Please answer all questions before the time of your examination. Explain all "yes" answers in the space provided.

	YES	NO
1. Are you currently under doctor's care for any reason?	☐	☐
2. Have you ever been hospitalized overnight?	☐	☐
3. Have you ever had surgery?	☐	☐
4. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	☐	☐
5. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
6. Do you have any allergies (pollen, medicine, good, or stinging insects)?	☐	☐
7. Have you ever had a rash or hives develop during or after exercise?	☐	☐
8. Have you ever been dizzy or passed our during or after exercises?	☐	☐
9. Have you ever had chest pain during or after exercise?	☐	☐
10. Do you get tire more quickly than your friends do during exercise?	☐	☐
11. Have you ever had high blood pressure or high cholesterol?	☐	☐
12. Have you ever been told that you have a heart murmur?	☐	☐
13. Have you ever had racing of your heart or skipped heart-beats?	☐	☐
14. Has any of your family died of heart problems or sudden death before age 50?	☐	☐
15. Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
16. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
17. Have you ever had a head injury or concussion?	☐	☐
18. Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
19. Have you ever had a seizure?	☐	☐
20. Do you have frequent or severe headaches?	☐	☐
21. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐	☐
22. Have you ever had a stinger, burner, or pinched nerve?	☐	☐
23. Have you ever become ill from exercising in the heat?	☐	☐
24. Have you ever been dizzy or passed out in the heat?	☐	☐
25. Do you have any trouble breathing or do you cough, wheeze or have trouble breathing during or after exercise?	☐	☐
26. Do you have asthma?	☐	☐
27. Do you use any special equipment (braces, neck rolls, mouth guards)?	☐	☐
28. Do you have any seasonal allergies that require medical treatment?	☐	☐
29. Do you have any current skin problems (itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
30. Have you ever had an eating disorder?	☐	☐
31. Have you ever had any problems with your eyes or vision?	☐	☐
32. Do you wear glasses or contacts or protective eye wear?	☐	☐
33. Do you have only one working organ of usually paired organs (only one eye, kidney, etc.)?	☐	☐
34. Have you ever sprained, broken, dislocated or had repeated swelling or pain of any bones or joints?	☐	☐
If answered "Yes", where? ☐ ankle ☐ elbow ☐ forearm ☐ hip ☐ shin/calf ☐ upper arm ☐ back ☐ finger ☐ hand ☐ knee ☐ shoulder ☐ wrist ☐ chest ☐ foot ☐ head ☐ neck ☐ thigh		
35. Have you ever had any problems or injuries since your last medical evaluation?	☐	☐
36. Do you want to weigh more or less than you do now?	☐	☐
37. Do you lose weight regularly to meet requirements for your sport?	☐	☐
38. Do you feel stressed out?	☐	☐

39. Record the dates of your most recent immunization shots for:

Tetanus: _____ Measles: _____

Hepatitis B: _____ Chickenpox: _____

FEMALES ONLY

40. When was your first menstrual period? _____

Date of last menstrual period: _____

What was the longest time between your periods during the past year? _____

EXPLAIN ALL 'YES' ANSWERS BY QUESTION NUMBER:

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

_____ **Date:** _____

Signature of Athlete

_____ **Date:** _____

Signature of Parent/Guardian (if athlete is under 18 years of age)

Perm ID: _____

Last Name: _____

First Name: _____

Physical Exp. Date: _____

DO NOT WRITE BELOW – FOR PHYSICIAN'S USE ONLY

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Pulse: _____ BP: _____ / _____ (_____ / _____ , _____ / _____)

Vision: R 20/ _____ L 20/ _____ Corrected: Y N Pupils Equal: _____ Unequal:: _____

MEDICAL	NORMAL	ABNORNAL FINDINGS	INITIALS
Appearance			
Eyes / Ears / Nose / Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (Males Only)			
Skin			

MUSCULOSKELETAL	NORMAL	ABNORNAL FINDINGS	INITIALS
Neck			
Back			
Shoulder / Arm			
Elbow / Forearm			
Wrist / Hand			
Hip / Thigh			
Knee			
Leg / Ankle			
Foot			

CLEARANCE

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: _____

_____

_____

☐ Not cleared for: _____ Reason: _____

Recommendations: _____

_____

_____

Name of Physician (print/type): _____ Date: _____

Address: _____ Telephone: _____ Fax: _____

Signature of Physician: _____ MD or DO

Perm ID: _____ **Last Name:** _____ **First Name:** _____ **Physical Exp. Date:** _____