

CALIFORNIA SPORTS PHYSICALS

"Making sports physicals convenient."

Instructions

Please print and complete the **parent consent form** and the top portion of the physical form prior to your arrival to your examination.

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Parent Consent Form

I, _____, parent or legal guardian of
(parent/guardian name)

_____, born ____/____/____, do hereby authorize
(student athlete name) (student athlete's date of birth)

a sports/school physical on ____/____/____ at _____.
(date of sports physical exam) (school/location of sports physical exam)

I understand this is a pre-season sports physical screening exam. It is not a comprehensive exam and it is not intended to provide treatment nor to create a physician/patient relationship. I understand that athletic participation comes with the risk of injury. This screening exam cannot detect all problems or prevent injury from athletic participation. I understand that if follow-up evaluation is recommended, it is my responsibility to seek care from an appropriate provider.

I certify I am the parent/legal guardian for this athlete/minor. I understand the information above.

Signature of Parent/Guardian

____/____/____
Date

(____)____-____
Parent/Guardian Day Contact Number

(____)____-____
Parent/Guardian Cell or Pager Number



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Preparticipation Physical Evaluation

HISTORY FORM

DATE OF EXAM _____

Name _____ Sex _____ Age _____ Date of birth _____

Grade _____ School _____ Sport(s) _____

Address _____ Phone _____

Personal physician _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ (W) _____

**Explain "Yes" answers below.
Circle questions you don't know the answers to.**

- | | |
|--|---|
| <p>1. Has a doctor ever denied or restricted your participation in sports for any reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Do you have an ongoing medical condition (like diabetes or asthma)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you have any allergies to medicines, pollens, foods, or stinging insects? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have you ever passed out or nearly passed out DURING exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you ever passed out or nearly passed out AFTER exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you ever had discomfort, pain, or pressure in your chest during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Does your heart race or skip beats during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Has a doctor ever told you that you have (check all that apply):
 <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur
 <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection</p> <p>10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Has anyone in your family died for no apparent reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Does anyone in your family have a heart problem? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Has any family member or relative died of heart problems or of sudden death before age 50? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Does anyone in your family have Marfan syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Have you ever spent the night in a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <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 affected area below: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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"/> Yes <input type="checkbox"/> No</p> | <p>24. Do you cough, wheeze, or have difficulty breathing during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>25. Is there anyone in your family who has asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>26. Have you ever used an inhaler or taken asthma medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>28. Have you had infectious mononucleosis (mono) within the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>29. Do you have any rashes, pressure sores, or other skin problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>30. Have you had a herpes skin infection? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>31. Have you ever had a head injury or concussion? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>32. Have you been hit in the head and been confused or lost your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>33. Have you every had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>34. Do you have headaches with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>36. Have you ever been unable to move your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>37. When exercising in the heat, do you have severe muscle cramps or become ill? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>39. Have you had any problems with your eyes or vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>40. Do you wear glasses or contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>41. Do you wear protective eyewear, such as goggles or a face shield? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>42. Are you happy with your weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>43. Are you trying to gain or lose weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>44. Has anyone recommended you change your weight or eating habits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>45. Do you limit or carefully control what you eat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>46. Do you have any concerns that you would like to discuss with a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>FEMALES ONLY</p> <p>47. Have you ever had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>48. How old were you when you had your first menstrual period? _____</p> <p>49. How many periods have you had in the last 12 months? _____</p> <p>Explain "Yes" answers here: _____

 _____</p> |
|--|---|

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/toes

20. Have you ever had a stress fracture? Yes No
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? Yes No
22. Do you regularly use a brace or assistive device? Yes No
23. Has a doctor ever told you that you have asthma or allergies? Yes No

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.
 Signature of athlete _____ Signature of parent/guardian _____ Date _____

Preparticipation Physical Evaluation

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 _____

Follow-Up Questions on More Sensitive Issues

	Yes	No
1. Do you feel stressed out or under a lot of pressure?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you feel safe?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?	<input type="checkbox"/>	<input type="checkbox"/>
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?	<input type="checkbox"/>	<input type="checkbox"/>
6. During the past 30 days, have you had a least 1 drink of alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever taken steroid pills or shots without a doctor's prescription?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>
9. Questions from the Youth Risk Behavior Survey (http://www.cdc.gov/HealthyYouth/yrbs/index.htm) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc.	<input type="checkbox"/>	<input type="checkbox"/>

Notes: _____

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)*			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only.

*Having a third party present is recommended for the genitourinary examination.

Notes: _____

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

Address _____ Phone: _____

Signature of physician _____, MD or DO