Santa Cruz City Schools
Pre-Physical Information Sheet

To be completed by Parent/Guardian

Student Name: _____ Birthdate: _____ Current Grade Level:_____

Highschool: _____Physician/Pediatrician: _____

Please click the box next to any question that would be answered with a Yes:

- ☐ 1. Are you under a doctor's care for any reason?
- ☐ 2. Have you ever been hospitalized or had surgery?
- ☐ 4. Are you currently taking any medication, inhalers or pills?
- ☐ 5. Do you have any allergies? (bee stings, medicines, food etc.)
- ☐ 6. Have you ever been dizzy or passed out during or after exercise?
- ☐ 7. Have you ever had chest pains during or after exercise?
- ☐ 8. Have you ever had high blood pressure?
- ☐ 9. Have you ever been told you have a heart murmur?
- ☐ 10. Have you ever had racing of your heart or skipped heartbeats?
- ☐ 11. Have you ever had a head injury or been knocked out or unconscious?
- ☐ 12. Have you ever had a seizure?
- ☐ 13. Have you ever had a stinger, burner, or pinched nerve?
- ☐ 14. Have you ever been dizzy or passed out in the heat?
- ☐ 16. Do you have trouble breathing or coughing during or after exercise?
- ☐ 17. Do you have any skin problems such as rashes, itching, etc?
- ☐ 18. Do you have any problems with your eyes, vision, wear contacts or glasses?
- ☐ 20. Do you use any special equipment such as splints, neck rolls, mouth guards, etc?
- ☐ 21. Has anyone in your family died of heart problems or sudden death before age 50?
- ☐ 22. Do you have only one working organ of usually paired organs (kidneys, eyes, etc)?
- ☐ 23. Do you have any other medical problems such as asthma, mono, diabetes, etc?
- ☐ 24. Have you had any medical injuries or issues since your last medical evaluation?
- ☐ 25. Any Special instructions/precautions the school/coaches should be aware of ?
- ☐ 26. Did you get your tetanus/Tdap booster before 7th grade?
- ☐ 27. Do you use any tobacco products?
- ☐ 28 **WOMEN ONLY -** Are you having irregular periods?
- ☐ 29. Have you ever sprained, broken, dislocated, or had repeated swelling of any bones or joints?
  If answered yes to the above question, please circle the area of concern **:**
  Head Neck Jaw Chest Clavicle Ankle Shin Calf Shoulder Back Foot Hand Wrist
  Elbow Forearm Shoulder Upper Arm Hip Groin Thigh Knee
- ☐ 30. Do any of the injuries circled in the last question currently bother you?

IF YOU CHECK YES TO ANY OF THE QUESTIONS LISTED ABOVE, PLEASE PROVIDE A COMPLETE EXPLANATION ON THE REVERSE SIDE OF THIS PAGE.

I/We hereby state that to the best of my/our knowledge, the answers are correct. I/we understand that by performing this examination, the undersigned physician does not assume responsibility for the medical care of this individual.

Athlete Signature:_____Date: _____

Parent/Guardian Signature:_____ Date:_____

Santa Cruz City Schools
Pre-Participation Physical

To be complete by Physician

Athlete's Name: _____ Date:_____
Height:_____ Weight:_____ BP:_____/_____ Pulse:_____
Vision: Pass/Refer

Medical	**Normal**	**Abnormal**
Skin		
Eyes / Ears / Nose / Throat		
Lymph Nodes		
Heart		
Pulse		
Lungs		
Abdomen		
Musculoskeletal	**Normal**	**Abnormal**
Neck		
Back		
Shoulder / Arm		
Elbow / Forearm		
Wrist / Hand		
Hip / Thigh		
Knee		
Leg		
Ankle / Foot		

Cleared for all Activities

Not Cleared for All Activities Due to _____

Physician Name_____ Physician Signature_____

Date:_____