

School Site: _____

Sacramento City Unified School District

PART 1 (TO BE COMPLETED BY A PARENT OR LEGAL GUARDIAN)									
LAST NAME				FIRST NAME				GRADE	
BIRTHDATE		FALL SPORT		WINTER SPORT		SPRING SPORT		STUDENT ID NUMBER	
PART 1 -- HEALTH HISTORY (Must be Completed by Parent/Guardian Prior to the Examination)									
	Yes	No	Has this student had:						
1.	☐	☐	Chronic or recurrent illness?		16.	☐	☐	Injuries requiring medical care or treatment?	
2.	☐	☐	Illness lasting over 1 week?		17.	☐	☐	Neck or back pain or injury?	
3.	☐	☐	Hospitalizations or Surgeries?		18.	☐	☐	Knee pain or injury?	
4.	☐	☐	Nervous, psychiatric, or neurologic condition?		19.	☐	☐	Shoulder or elbow pain or injury?	
5.	☐	☐	Loss or nonfunctioning of organs (eye, kidney, liver, testicle) or glands?		20.	☐	☐	Ankle pain or injury?	
6.	☐	☐	Allergies (medicines, insect bites, food)?		21.	☐	☐	Other joint pain or injury?	
7.	☐	☐	Problems with heart or blood pressure?		22.	☐	☐	Broken bones (fractures)?	
8.	☐	☐	Chest pain or significant or severe shortness of breath during or after exercise?		23.	☐	☐	Does this student presently:	
9.	☐	☐	Dizziness or fainting with exercise?		24.	☐	☐	Wear eyeglasses or contact lenses?	
10.	☐	☐	Fainting, bad headaches or convulsions?		25.	☐	☐	Wear dental bridges, braces or plates?	
11.	☐	☐	Potential concussion or loss of consciousness?		26.	☐	☐	Take any medications? (List below):	
12.	☐	☐	Heat exhaustion, heatstroke, or other problems managing or responding to heat?		27.	☐	☐	Further history:	
13.	☐	☐	Racing heartbeat, skipped or irregular heartbeats, or heart murmur?		28.	☐	☐	Birth defects (corrected or not)?	
14.	☐	☐	Seizures or seizure disorders?		29.	☐	☐	Death of a parent or grandparent less than 40 years of age due to medical cause or condition?	
15.	☐	☐	Severe or repeated instances of muscle cramps?					Parent or grandparent requiring treatment for heart condition less than 50 years of age?	
								Been seen by a physician on an emergency or urgent basis in the last 12-months?	
Date of last known tetanus (lockjaw) shot: _____ Date of last complete physical examination: _____ <i>Explain all "YES" answers. Describe any other fact that should be disclosed prior to the examination (use reverse of form if needed):</i>									
PARENT/GUARDIAN'S AUTHORIZATION: I authorize the health care provider to perform a Sports Physical Evaluation on the student. The information set forth above is complete and accurate. I presently know of no reason why the student cannot fully and safely participate in the listed sports. For Sports Physical Evaluations that may be performed by District volunteers, I understand the evaluation is a screening evaluation only, and that I must address all health care concerns with the Student's personal physician or health care provider.									
PRINT NAME OF PARENT OR GUARDIAN					SIGNATURE OF PARENT OR GUARDIAN				
ADDRESS					WORK PHONE		HOME PHONE		DATE
REGULAR PHYSICIAN'S NAME				OFFICE PHONE					
PART 2 – MEDICAL EVALUATION (TO BE COMPLETED BY THE EXAMINING HEALTH CARE PROVIDER)									
This Evaluation Can Only be Performed by Medical Doctors (MDs), Doctors of Osteopathy (DOs), Physician's Assistants (P.A.s), and Nurse Practitioners (N.P.s)									
	NORMAL	ABNORMAL (Describe)					(May be contained on Provider's Form)		
Eyes/Ears/Nose/Throat							Height:		Weight:
Heart, lungs, pulmonary function							Pulse:		After Ex:
Abdomen, genital/hernia (males)							BP:		
Skin and Musculoskeletal:							Recommendation: ☐ Unlimited participation ☐ Limited participation/specific sports, events or activities ☐ Clearance withheld pending further testing/evaluation ☐ No athletic participation One of the above MUST be checked.		
a. Neck/Spine/Shoulders/Back									
b. Arms/Hands/Fingers									
c. Hips/Thighs/Knees/Legs									
d. Feet/Ankles									
Neurologic Screening Exam (NSE)/									
Concussion Screening Evaluation (only if needed based on above info.)									
Comments:									
PRINT NAME OF PHYSICIAN					PHYSICIAN'S SIGNATURE			DATE	