ATHLETIC/ASB DEPT. ONLY

1ST QUARTER GPA _____
2ND QUARTER GPA _____
3RD QUARTER GPA _____
5TH QUARTER GPA _____

# 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 APPROPRIATE BOXES)**

| | | | | | |
|---|---|---|---|---|---|
| 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:** _____

**Not cleared for:** **All sports:** YES ☐ NO ☐ **Certain sports:** YES ☐ NO ☐

**Reason and Recommendations:** _____

**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:** _____

ATHLETIC/ASB DEPT. ONLY

1ST QUARTER GPA _____
2ND QUARTER GPA _____
3RD QUARTER GPA _____
5TH QUARTER GPA _____

# Forma Física Atlética del Distrito de Escuelas Secundarias Conjuntas de Delano

**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 está al corriente:** _____

**Información Medica Relevante para los Entrenadores y el Departamento Atlético:**

**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 with restrictions:** YES ☐ NO ☐

**LIST RESTRICTIONS/LIMITATIONS:** _____

**Not cleared for:** **All sports:** YES ☐ NO ☐ **Certain sports:** YES ☐ NO ☐

**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:** _____