ATHLETIC/ASB DEPT. ONLY
1ST QUARTER GPA_____
2ND QUARTER GPA_____
3RD QUARTER GPA_____
4TH 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 APPROPERIATE BOX)

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: _____

If athlete is <u>NOT</u> cleared for sport(s) please explain:

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:** _____

ATHLETIC/ASB DEPT. ONLY
1ST QUARTER GPA_____
2ND QUARTER GPA_____
3RD QUARTER GPA_____
4TH QUARTER GPA_____

Delano Joint Union High School District Forma Física Atlética

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 esta al corriente: _____

Información Medica Relevante para los Entrenadores y el Departamento Atlético:

Alergias: _____ **EpiPen Necesaria:** **SI** ☐ **NO** ☐

Asma: **SI** ☐ **NO** ☐ **Medicamento de EMERGENCIA:** _____

Diabetes: **SI** ☐ **NO** ☐ **Medicamento de EMERGENCIA:** _____

Trastorno Convulsivo: **SI** ☐ **NO** ☐ **Medicamento de EMERGENCIA:** _____

EVALUACION FISICA

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: _____

If athlete is NOT cleared for sport(s) please explain:

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:** _____