Centinela Valley Union High School District
Preparticipation Physical Evaluation

Female___Male ___
Year _____
ID# _____

Print Last Name | First Name | Middle Initial | Grade | Sport

Address | City | Zip | Home Phone Number

Father/Guardian's Name | Father/Guardian's Phone Number | Mother/Guardian's Name | Mother/Guardian's Phone No.

Father's Work Number | Mother's Work Number | Others to Call in Emergency (Name and Phone Number)

HEALTH HISTORY (To be completed by student & parent): Check "yes" or "no" and give as much information as possible.

___Yes___No Heart Trouble ___Yes___No Asthma ___Yes___No Diabetes ___Yes___No Seizures

___Yes___No Palpitations ___Yes___No Fatigue ___Yes___No High Blood Pressure ___Yes___No Chest Pain

___Yes___No Current Skin Condition ___Yes___No Dizziness/Fainting ___Yes___No Extreme Shortness of Breath/Wheezing

___Yes___No Kidney Problems ___Yes___No History of family member with heart attack under 50yrs of age or sudden death.

___Yes___No Other: Glasses/Contacts, Protective Equipment, or Hearing Aid ___Yes___No Head Trauma/Loss of Consciousness

Other: _____

History of any previous injuries, fractures, serious illnesses or operations/hospitalizations (describe and give approximate dates)

Current medications | Allergies | Date of Last Tetanus Shot

PARENT CONSENT

I hereby state that the above information is true and correct and give my consent for the above-named student to compete in sports and go with a representative of the school on any trips. In case of injury, the school representative is authorized to have him/her treated.

▶ _____ ▶ _____ ▶ _____ ▶ _____

Date | Parent/Guardian Signature | Name of Insurance Co. | Policy/Group Number

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PHYSICAL EXAMINATION (To be completed by physician):

Visual Acuity (Distance): O.D._____/_____O.S._____/_____( ) Corrected ( ) Uncorrected

Height_____ Weight_____ Blood Pressure_____ Pulse_____

Normal	Normal
1. Eyes, Ears, Nose, Throat	9. Musculoskeletal
2. Neck	Neck
3. Cardiovascular	Spine
EKG results (if done)	Shoulders
4. Chest and Lungs	Arms/Hands
5. Abdomen	Hips
6. Skin	Thighs
7. Genitalia-Hernia (male)	Knees
8. Neuromuscular	Ankles
	Feet

Comments: _____

RECOMMENDATION:
( ) Full Activity – No restrictions
( ) Activity with restrictions: _____
( ) No contact sports ( ) No Participation
( ) Other _____

PHYSICIAN'S STAMP

EXAMINING PHYSICIAN: **Phone:** ▶ _____

DATE OF EXAM: ▶ _____ **LICENSE #:** ▶ _____

Print name: ▶ _____

Signature: ▶