

[PLEASE PRINT]

EL DORADO UNION HIGH SCHOOL DISTRICT Sports Participation Health Record

2016/2017 _____

UMHS

— This form must be completed every academic year —

NAME		AGE	SEX (CIRCLE) <input type="checkbox"/> M <input type="checkbox"/> F	GRADUATION YEAR
ADDRESS		CITY	ZIP	PHONE

- | | | | | | | | |
|-------------------------------------|--|-----------------------------------|--|-----------------------------------|--|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Baseball | <input type="checkbox"/> Cheerleading | <input type="checkbox"/> Football | <input type="checkbox"/> Lacrosse | <input type="checkbox"/> Soccer | <input type="checkbox"/> Swimming/Diving | <input type="checkbox"/> Track | <input type="checkbox"/> Water Polo |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Cross-country | <input type="checkbox"/> Golf | <input type="checkbox"/> Skiing/
Snowboarding | <input type="checkbox"/> Softball | <input type="checkbox"/> Tennis | <input type="checkbox"/> Volleyball | <input type="checkbox"/> Wrestling |

PART A HEALTH HISTORY

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	1. Have you ever had an illness or injury that: a. Required you to stay in the hospital, <i>explain</i> :
<input type="checkbox"/>	<input type="checkbox"/>	b. Lasted longer than a week, <i>explain</i> :
<input type="checkbox"/>	<input type="checkbox"/>	c. Is related to allergies, e.g., hay fever, hives, bee sting, <i>explain</i> :
<input type="checkbox"/>	<input type="checkbox"/>	d. Required an operation, <i>explain</i> :
<input type="checkbox"/>	<input type="checkbox"/>	e. Is chronic, e.g., asthma, diabetes, seizures*, <i>explain</i> :
<input type="checkbox"/>	<input type="checkbox"/>	2. Do you take medications or pills, specify:
<input type="checkbox"/>	<input type="checkbox"/>	3. Have any members of your family under age 50 had a heart attack or died unexpectedly, <i>explain</i> :
<input type="checkbox"/>	<input type="checkbox"/>	4. Have you ever been: a. Dizzy or passed out during or after exercise, <i>explain</i> :
<input type="checkbox"/>	<input type="checkbox"/>	b. Unconscious or had a concussion, <i>explain</i> :
<input type="checkbox"/>	<input type="checkbox"/>	5. Does running the 1/2-mile give you difficulty, <i>explain</i> :
<input type="checkbox"/>	<input type="checkbox"/>	6. Do you wear glasses or contacts, <i>explain</i> :
<input type="checkbox"/>	<input type="checkbox"/>	7. Do you have dental bridges, plates, or braces, <i>explain</i> :
<input type="checkbox"/>	<input type="checkbox"/>	8. Have you ever had a heart murmur, high blood pressure, or a heart abnormality, <i>explain</i> :
<input type="checkbox"/>	<input type="checkbox"/>	9. Do you have any allergies to medicines, <i>explain</i> :
<input type="checkbox"/>	<input type="checkbox"/>	10. Are you missing a kidney, lung, eye, or testicle, <i>explain</i> :
<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had severe arm or neck pain, <i>explain</i> :
<input type="checkbox"/>	<input type="checkbox"/>	12. Have you sprained, strained, dislocated, or broken any of the following: <input type="checkbox"/> Ankle <input type="checkbox"/> Elbow <input type="checkbox"/> Hip <input type="checkbox"/> Neck <input type="checkbox"/> Other, <i>explain</i> : <input type="checkbox"/> Back <input type="checkbox"/> Foot <input type="checkbox"/> Humerus <input type="checkbox"/> Pelvis <input type="checkbox"/> Chest/Ribs <input type="checkbox"/> Forearm <input type="checkbox"/> Knee <input type="checkbox"/> Shoulder <input type="checkbox"/> Collarbone <input type="checkbox"/> Hand <input type="checkbox"/> Leg <input type="checkbox"/> Wrist

*A swim seizure form is required for swim activities

I, hereby, state the answers on form are correct to the best of my knowledge. I have also read and agree to the contents of the athletic handbook.

X _____

Signature of Student Athlete

Date

I agree with the health history and give my permission for an examination. I have also read and agree to the contents of the athletic handbook.

X _____

Signature of Parent / Guardian

Date

PART B PHYSICAL EXAMINATION RECORD (TO BE COMPLETED BY A LICENSED MEDICAL DOCTOR)

Height (inches) _____ Blood Pressure _____ / _____ Vision (Right) _____

Weight (pounds) _____ Pulse _____ Vision (Left) _____

CORE EXAMINATION	NORMAL	ABNORMAL FINDINGS	INITIALS
a. Eyes			
b. Ears, Nose, Throat			
c. Mouth, Teeth			
d. Neck			
e. Cardiovascular			
f. Chest, Lungs			
g. Abdomen			
h. Skin			
i. Genitalia, Hernia			

ORTHOPEDIC EXAMINATION	NORMAL	ABNORMAL FINDINGS	INITIALS
a. Neck			
b. Spine			
c. Shoulders			
d. Arms, Elbows			
e. Forearms, Wrists, Hands			
f. Hips			
g. Knees, Legs			
h. Ankles, Feet			
i. Flexibility			
j. Neuromuscular			

Abnormalities found in the health history and/or physical examination that needs assessment:

RECOMMENDATIONS: Approved for full participation Needs to have the above abnormalities cleared before participation.
 Disqualified or limited in the following sports:

X _____
 Licensed Medical Doctor's Signature

Date: _____

 Licensed Medical Doctor's Printed Name

 Licensed Medical Doctor's Address