

Current School _____

Current Grade 8 9 10 11 12

**SHASTA UNION HIGH SCHOOL DISTRICT
Athletic Health Screening Examination Record**

Student Name _____ Date of Birth _____ Telephone # _____

Age: _____ Gender: _____ Height: _____ Weight: _____

**Health Screening Examination
(to be completed and signed by a physician)**

Pulse Rate: _____ Blood Pressure: _____

**Health History
(to be completed and signed by parent/guardian)**

Has your child ever had or does he/she now have any of the following?

Yes No (Please explain any yes answers)

- 1. Chronic or recurrent illnesses _____
- 2. Illnesses lasting more than a week _____
- 3. Hospitalizations _____
- 4. Surgery, other than tonsillectomy _____
- 5. Problem with blood pressure or heart _____
- 6. Dizziness, fainting or frequent headaches _____
- 7. Ever been knocked out or had a concussion or lost memory _____
- 8. Neck/back injury or surgery, numbness or tingling in arms, hands, legs or feet _____
- 9. A stinger, burner or pinched nerve? _____
- 10. Knee, ankle injury or surgery _____
- 11. Other joint sprains or dislocation, pain or swelling _____
- 12. Broken bones (fractures) _____
- 13. Epilepsy or seizure disorder _____
- 14. Asthma or shortness of breath _____
- 15. Diabetes _____
- 16. Illness from exercising in the heat _____
- 17. Nervous disorder or mental illness _____
- 18. Currently taking any medications _____
- 19. Allergic to any medications (aspirin, penicillin, etc.) or bee stings _____
- 20. Wear eyeglasses or contact lenses _____
- 21. Wear dental appliances, othotics or prosthetic equipment _____
- 22. Desire to weigh more or less than current weight. Lose weight regularly to meet weight requirements for sports _____
- 23. Stressed out feeling _____

Please use this space to further explain the above answers or for additional information:

Parent/Guardian Permission and Release

I declare that the above information is correct to the best of my knowledge. I understand this is a screening examination to determine if any obvious medical problems exist to prevent my child from participating in school athletic events. This examination is not a complete medical examination. You should contact your family physician for your medical needs. If any medical problems are identified in this screening examination, further examination and treatment should be obtained through your physician.

Parent/Guardian Signature

Date

	Normal	Abnormal	Comments
Eyes/Ears/Nose/Throat			
Lymph nodes			
Heart			
Lungs			
Abdomen			
Genitalia/Hernia (males only)			
Skin			
Neck/Spine			
Arms/Shoulders/Elbows			
Wrists/Hands			
Legs/Hips/Thighs/Knees			
Ankles/Feet			

Based on this history and physical exam the following ABNORMALITIES were found and need further evaluation before clearance for competitive athletics:

- 1. _____
- 2. _____
- 3. _____

Recommendations:

- CLEARED - There were no history or physical findings on this exam which would prohibit this student from participating in competitive athletics.
- This student should have the above health problems evaluated or treated PRIOR to participating in competitive athletics.
- This student has health problems which would PROHIBIT him or her from participating in competitive athletics.

Physician Name (print/type)

Phone

Physician Signature

Date