TWIN RIVERS UNIFIED SCHOOL DISTRICT
SPORTS PHYSICAL EXAMINATION FORM

PART 1 (TO BE COMPLETED BY A PARENT OR LEGAL GUARDIAN)

LAST NAME	FIRST NAME	GRADE

BIRTHDATE	FALL SPORT	WINTER SPORT	SPRING SPORT

PART 1 -- HEALTH HISTORY (Must be Completed by Parent/Guardian Prior to the Examination)

	YES	NO	Has this student had:		YES	NO	
1	☐	☐	Chronic or recurrent illness?	16	☐	☐	Injuries requiring medical care or treatment?
2	☐	☐	Illness lasting over one (1) week?	17	☐	☐	Neck or back pain or injury?
3	☐	☐	Hospitalizations or surgeries?	18	☐	☐	Knee pain or injury?
4	☐	☐	Nervous, psychiatric or neurologic conditions?	19	☐	☐	Should or elbow pain or injury?
5	☐	☐	Loss of nonfunctioning of organs (eye, kidney, liver, testicle or glands)?	20	☐	☐	Ankle pain or injury?
6	☐	☐	Allergies to medicines, insect bites or food?	21	☐	☐	Other joint pain or injury?
7	☐	☐	Problems with heart or blood pressure?	22	☐	☐	Broken bones (fractures)?
8	☐	☐	Chest pain or significant or severe shortness of breath during or after exercise?		YES	NO	**Does this student presently:**
9	☐	☐	Dizziness or fainting with exercise?	23	☐	☐	Wear eyeglasses or contact lenses?
10	☐	☐	Fainting, bad headaches or convulsions?	24	☐	☐	Wear dental bridges, braces or plates?
11	☐	☐	Potential concussion or loss of consciousness?	25	☐	☐	Take any medication? (List below)
12	☐	☐	Heat exhaustion, heatstroke, or other problems managing or responding to heat?		YES	NO	**Further history:**
13	☐	☐	Racing heartbeat, skipped or irregular heartbeats, or heart murmur?	26	☐	☐	Birth defects (corrected or not)?
14	☐	☐	Seizures or seizure disorders?	27	☐	☐	Death of parent/grandparent less than 40 years of age due to medical cause or condition?
15	☐	☐	Severe or repeated instances of muscle cramps?	28	☐	☐	Parent/grandparent requiring treatment for heart condition less than 50 years of age?
				29	☐	☐	Been seen by a physician on an emergency or urgent basis in the last 12 months?

Date of last known tetanus (lockjaw) shot:_____ ***Date of last complete physical examination:_____***

Explain all " YES" Describe any other fact that should be disclosed prior to the examination (use reverse of form if needed:

PARENT/GUARDIAN'S AUTHORIZATION: I authorize the health care provider to perform a Sports Physical Evaluation on the student. The Information set forth above is complete and accurate. I presently know of no reason why the student cannot fully and safely participate in the listed sports. For Sports Physical Evaluations that may be performed by District volunteers, I understand the evaluation is a screening evaluation only, and that I must address all health care concerns with the Student's personal physician or health care provider.

PRINT NAME OF PARENT ORGUARDIAN	SIGNATURE OF PARENT OR GUARDIAN	
ADDRESS	**WORK PHONE**	**HOME PHONE**

REGULAR PHYSICIAN'S NAME	OFFICE PHONE	OFFICE ADDRESS:

PART 2 – MEDICAL EVALUATION (TO BE COMPLETED BY THE EXAMINING HEALTH CARE PROVIDER)

This Evaluation Can Only be Performed by Medical Doctors (MDs), Doctors of Osteopathy (DOs), Physician's Assistants (P.A.s), and Nurse Practitioners (N.P.s)

	NORMAL	ABNORMAL (Describe)	(May be contained on Provider's Form)
Eyes/Ears/Nose/Throat			**Height:** **Weight:**
Heart, lungs, pulmonary function			**Pulse:** **After Ex:**
Abdomen, genital/hernia (males)			**BP:**
Skin and Musculoskeletal:			**Recommendation:** ***One MUST be checked.***
a. Neck/Spine/Shoulders/Back			☐ Unlimited participation
b. Arms/Hands/Fingers			☐ Limited participation/specific sports, events or activities
c. Hips/Thighs/Knees/Legs			☐ Clearance withheld pending further testing/evaluation
d. Feet/Ankles			☐ No athletic participation
Neurologic Screening Exam (NSE)/			
Concussion Screening Evaluation(only if needed based on above info.)			

Comments (use reverse of form if necessary)

PRINT NAME OF PHYSICIAN	PHYSICIAN'S SIGNATURE	DATE