

PARTICIPATION IN EXTRACURRICULAR ACTIVITIES PHYSICAL EXAM FORM

(STUDENT'S LAST NAME) (FIRST) (MIDDLE)

Press Firmly - Multiple Copies School: _____ Grade: _____

_____ Birthdate: _____ Phone: _____
 (Student's Last Name) (First) (Middle)

Address: _____ Family Dr's _____
 Dr: _____ Phone: _____

The above named student has my permission to participate in extracurricular activities and to travel with a representative of the school on any trips. In case of injury the school representative is authorized to have him/her treated or hospitalized by any one of the doctors cooperating with the school program, and I will not hold Grossmont Union High School District or its representatives responsible for payment as the result of any accident or injury.

MEDICAL HISTORY (to be completed by parent)

R or L Handed: _____	Allergies to medicines: _____	
Has athlete had the following:		
	Yes _____	No _____ Explain "Yes" Answers
1. Injuries to head, neck, bones or joints	Yes _____	No _____
2. Any other injuries requiring medical attention	Yes _____	No _____
3. Seizures, blackouts or any episode of unconsciousness	Yes _____	No _____
4. Heart Trouble, Heart Murmur, High Blood Pressure	Yes _____	No _____
5. Any serious infectious disease	Yes _____	No _____
6. Hospitalization or operations in the past	Yes _____	No _____
7. Stomach, Intestinal, or Urinary Tract problems	Yes _____	No _____
8. Is athlete under care of a doctor now	Yes _____	No _____
9. Is athlete taking any medicine on a regular basis	Yes _____	No _____
10. Complex Dental Problems	Yes _____	No _____

Parent/Guardian/Caregiver Signature: _____ Date: _____

Emergency Contact if parents cannot be reached: _____ Phone: _____

PHYSICAL EXAMINATION (to be completed by physician)

Date: _____	Head: _____
Height: _____	Neck: _____
Weight: _____	Heart: _____
Blood Pressure: _____	Lungs: _____
Pulse: _____	Chest (including breasts): _____
General Appearance: _____	Abdomen: _____
	Genitalia (including hernias): _____
	Back and Extremities: _____
	Neurological: _____
	Derm: _____

From the above information and the screening physical exam, in my opinion this student is is not physically able to participate in competition.

Is further consultation necessary? Yes No Specialty: _____

SIGNED: _____, M. D. DATE: _____ PHONE: _____

FOR COACH'S AND/OR BOOKKEEPER'S USE: ASB Card: _____, Physical: _____, Clearance: F W S
SIGNED PARENT PERMISSION FORM ON FILE:

- | | |
|--|---|
| <input type="checkbox"/> OPTION A - Student Accident Insurance
<input type="checkbox"/> Football Only
<input type="checkbox"/> School Time
<input type="checkbox"/> Full Time (24 hours)
<input type="checkbox"/> Dental
<input type="checkbox"/> Spring Football | <input type="checkbox"/> OPTION B - Own Insurance or Health Plan
<input type="checkbox"/> Football Only
<input type="checkbox"/> Other Sports
Name of Insurance Co. or Plan: _____
Policy No. _____ |
|--|---|