Section C - Student-Athlete Medical History

ATHLETE'S NAME

ATHLETE'S & PARENT/GUARDIAN SIGNATURE

We, the athlete and parent/guardian, certify that the below health history information is correct and accurate to the best of our knowledge. We know of no health reasons that disqualifies me/our student athlete from participating in interscholastic athletics.

STUDENT SIGNATURE _____ PARENT / GUARDIAN SIGNATURE _____ DATE _____

PARENTS AND STUDENT ANSWER THE FOLLOWING MEDICAL HISTORY QUESTIONS.

DO YOU OR HAVE YOU EXPERIENCED ANY OF THE FOLLOWING CONDITIONS.

Yes No 1. ***Concussion or had your "bell rung" ?***
Yes No 2. Frequent headaches, Dizziness or Fainting spells?
Yes No 3. Neck injury involving nerves, bones, or spinal cord, including "stingers" or "burners"?
Yes No 4. Back or Neck injury, or low back pain that required medical treatment?
Yes No 5. Fractured bone or a stress fracture?
Yes No 6. Significant musculoskeletal injury? I.e. shin splints, pelvic injuries, stains or sprains to knee, ankle, wrist, shoulder, elbow
Yes No 7. Anemia?
Yes No 8. Depression?
Yes No 9. Diabetes?
Yes No 10. Epilepsy or seizures?
Yes No 11. A hernia?
Yes No 12. Kidney disease, Liver disease or hepatitis?
Yes No 13. Mononucleosis?
Yes No 14. Recurring anxiety?
Yes No 15. Skin problems?
Yes No 16. Stomach ulcers?
Yes No 17. Unusual bleeding or bruising?
Yes No 18. Eating disorders, Weight loss or gain greater than 10 lbs. I.e. bulimia (bingeing or vomiting), anorexia nervosa
Yes No 19. Asthma or wheezing
Yes No 20. A pain or pressure in the chest?
Yes No 21. Chest Pain or shortness of breath?
Yes No 22. Spitting or coughing up blood?
Yes No 23. A need to take any kind of medicine?
Yes No 24. Drugs or medicine to enhance athletic ability or strength?
Yes No 25. A dependency on medicine, drugs, or alcohol, smoking,tobacco or other substance?
Yes No 26. A dental plate or a broken or chipped tooth?
Yes No 27. Are you missing any organs? [kidney, eye, etc.]
Yes No 28. Injury while participating in sports?
Yes No 29. Surgery or hospitalization not noted above?
Yes No 30. Any illness or injury not already noted?

HAVE YOU OR A FAMILY MEMBER HAD ANY OF THE FOLLOWING CONDITIONS.

If yes provide approximate date(s) and details; if a family member, specify relation to you.

Yes No 31. Heart murmur?
Yes No 32. Chest pain or heart palpitations with or without exercise?
Yes No 33. Fainting or near fainting, passing out?
Yes No 34. High blood pressure?
Yes No 35. Irregular heart beat or extra beats?
Yes No 36. Excessive or unexplained shortness of breath or excessive fatigue with exercise I.e.Asthma.
Yes No 37. Sudden death without warning before age 50?
Yes No 38. Other history of Heart problems? I.e. hypertrophic cardiomyopathy or dilated cardiomyopathy, long QT syndrome or Marfan's syndrome

FEMALE ATHLETES ONLY

Yes No 39. Are there any female health relate conditions that will effect your participation in athletics?

OTHER CONDITIONS THAT MAY EFFECT ATHLETIC COMPETITION?

Section D - Physician's Clearance Statement

PHYSICIAN'S INSTRUCTIONS

Our pre participation medical screening form for Liberty Union High School District student athletes is designed to set a minimum standard and is not all inclusive of tests, procedures, and examinations your may deem necessary. Please be as thorough as possible.

- **Please review the Student's Medical History ; it is designed to save you time in your examination.**
- **Complete the Physician's Physical Exam and sign it .**
- **After completing the physical form, please make copies for your medical records and return the original form to the student athlete who will return it to the athletic director.**

If you have any questions or need to talk to the Athletic Director regarding the athlete, please feel free to contact him at Heritage High School Athletic Department [925] 634-0037 x 6090

Height _____ **Weight** _____ **Vision None Contacts Glasses R 20/** _____ **L 20/** _____ **B 20/** _____

URINALYSIS:

Glucose _____
Protein _____
pH _____
Blood Ketones _____
Leukocytes _____
Test not Done _____

MUSCULOSKELETAL

Nml	Abn	
___	___	C-spine
___	___	Shoulders
___	___	Elbows
___	___	Wrist
___	___	Hands
___	___	Spine
___	___	Hips
___	___	Knees
___	___	Ankles
___	___	Feet

GENERAL ASSESSMENT

Nml	Abn	
___	___	Head
___	___	Concussion History
___	___	Eyes
___	___	ENT
___	___	Mouth/Teeth
___	___	Lungs
___	___	Abdomen
___	___	GU
___	___	Skin

___ ___ Neurological

CARDIOVASCULAR ASSESSMENT

Nml	Abn	
___	___	Blood Pressure Sitting _____/_____
___	___	Auscultation - Supine
___	___	Auscultation - Standing
___	___	Pulse _____ Pulse Rate _____
___	___	Physical Signs of Marfan's Syndrome [Screening if abnormal.]

DATE OF LAST TETANUS SHOT

STATEMENT OF MEDICAL CLEARANCE FOR INTERSCHOLASTIC ATHLETIC COMPETITION

I certify that I have reviewed the above student's medical history and the above medical screening information. I have supervised the screening and certify that the above student athlete is healthy enough to engage at a high level of athletic competition & sports as marked below.

- ☐ CLEARED FOR ATHLETIC ACTIVITIES
- ☐ Cleared with Precautions
- ☐ NOT Cleared at this time

Physician's Signature _____

Date _____

Please Print **Physician's Name** Address Phone No. State Medical License No.	