GRANADA HILLS CHARTER HIGH SCHOOL

HISTORY: **This side to be completed and signed by parent and student**
Opposite side to be completed, signed and stamped by MD,DO,NP or PA
Completed form to be turned into Health Office at least 48 hrs prior to tryouts

Name: ______________________ Sex: _____ Age: ______ Date of Birth: __________

Grade: _______ ID#__________ Sport(s): ______________________

Address: ______________________ Phone: (_____) __________

Personal Physician/Provider: ______________________

Explain "Yes" answers below.

	Yes	No
1. Do you think you are in good health?	☐	☐
2. Do you have an ongoing medical condition? (ex: diabetes or asthma)	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills?	☐	☐
4. Do you have any allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Has a physician ever denied or restricted your participation in sports for any reason?	☐	☐
6. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
7. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
8. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
9. Does your heart race or skip beats during exercise?	☐	☐
10. Has a doctor ever told you that you have (circle all that apply) High Blood Pressure, A Heart Murmur, High Cholesterol, A Heart Infection		
11. Has a doctor ever ordered a test for your heart? Example: ECG, echocardiogram	☐	☐
12. Has anyone in your family died for no apparent reason?	☐	☐
13. Does anyone in your family have a heart problem?	☐	☐
14. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
15. Does anyone in your family have Marfan syndrome?	☐	☐
16. Have you ever spent the night in a hospital?	☐	☐
17. Have you ever had surgery?	☐	☐
18. Have you ever had an injury, like a sprain, muscle, ligament tear, or tendinitis that caused you to miss a practice or game? If yes, circle affected area below:	☐	☐
19. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitations, physical therapy, a brace, a cast or crutches? If yes, circle below:	☐	☐

Head Neck Shoulder Upper Arm Elbow Chest Hand/Fingers Forearm

Ankle Foot/Toes Upper Back Lower Back Hip Thigh Knee Calf/Shin

	Yes	No
21. Have you ever had a stress fracture?	☐	☐
22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
23. Do you regularly use a brace or assistive device?	☐	☐
24. Has a doctor ever told you that you have asthma or allergies?	☐	☐
25. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
26. Is there anyone in your family who has asthma?	☐	☐
27. Have you ever used an inhaler or taken asthma medicine?	☐	☐
28. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
29. Have you had infectious mononucleosis within the last month?	☐	☐
30. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
31. Have you had a herpes skin infection?	☐	☐
32. Have you had any problems with your eyes or vision?	☐	☐
33. Do you wear glasses or contact lenses?	☐	☐
34. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
35. Are you happy with your weight?	☐	☐
36. Are you trying to gain or lose weight?	☐	☐
37. Has anyone recommended you change your weight or eating habits?	☐	☐
38. Do you limit or carefully control what you eat?	☐	☐
39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
40. Have you ever had a head injury or concussion?	☐	☐
41. Have you been hit in the head and been confused or lost your memory?	☐	☐
42. Have you ever had a seizure?	☐	☐
43. Do you have headaches with exercise?	☐	☐
44. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
45. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
46. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
47. Do you have any concerns that you would like to discuss with a doctor?	☐	☐

FEMALES ONLY

	Yes	No
48. Have you ever had a menstrual period?	☐	☐
49. How old were you when you had your first menstrual period?	______	
50. How many periods have you had in the last 12 months?	______	

Explain "Yes" Answers Here: ______________________

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I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ______________________ **Date:** __________

Signature of parent/guardian ______________________ **Date:** __________

PHYSICAL EXAMINATION FOR INTERSCHOLASTIC ATHLETICS

NAME______________________________ **Date of Birth**__________

Height______ Weight______ BMI (optional)______ Pulse______ BP ____/____ (____/____ , ____/____)

Vision: R 20/____ L 20/____ Corrected: Yes No Pupils: Equal ______ Unequal ______

EMERGENCY INFORMATION
Allergies/Other: ______________________________

	Normal	Abnormal Findings	Initials*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

Date of last Tdap booster: ____________ Varicella Documentation: ____________

CLEARANCE

❑ Cleared without restriction

❑ Cleared, with recommendations for further evaluation or treatment for:______________________________

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❑ Not cleared for: ❑ All Sports ❑ Certain Sports: ______________________________

Name of Physician/Provider: (print/type/stamp)______________________________(MD, DO, NP or PA)

Address: ______________________________ Phone: ____________

Signature of Physician/Provider: ______________________________ Date of Exam: ____________

THIS EXAM MUST HAVE A STAMP, SIGNATURE, AND DATE OF EXAM