Santa Cruz City Schools Athletic Clearance Packet

Harbor High Santa Cruz High Soquel High

405 Old San Jose Road, Soquel, California
95073 (831) 429-3410 www.sccs.net

Pre-Physical Information Sheet

To Be Completed by Parent / Guardian

Student Name _____

Age _____ Grade _____ Activity _____

Place a check by any questioned answered yes

____ 1. Are you under a doctor's care for any reason?
____ 2. Have you ever been hospitalized?
____ 3. Have you ever had surgery?
____ 4. Are you currently taking any medication, inhalers or pills?
____ 5. Do you have any allergies? (bee stings, medicines, etc)
____ 6. Have you ever been dizzy or passed out during or after exercise?
____ 7. Have you ever had chest pains during or after exercise?
____ 8. Have you ever had high blood pressure?
____ 9. Have you ever been told you have a heart murmur?
____ 10. Have you ever had racing of your heart or skipped heartbeats?
____ 11. Have you ever had a head injury?
____ 12. Have you ever been knocked out or unconscious?
____ 13. Have you ever had a seizure?
____ 14. Have you ever had a stinger, burner or pinched nerve?
____ 15. Have you ever been dizzy or passed out in the heat?
____ 16. Do you have trouble breathing or coughing during or after exercise?
____ 17. Do you have any skin problems such as rashes, itching, etc?
____ 18. Do you have any problems with your eyes or with your vision?
____ 19. Do you wear contacts, glasses or protective eye wear?
____ 20. Do you use any special equipment such as splints, neck rolls, mouth guards, etc?
____ 21. Has anyone in your family died of heart problems or sudden death before age 50?
____ 22. Do you have only one working organ of usually paired organs (kidneys, eyes, etc)?
____ 23. Have you ever sprained, broken, dislocated, or had repeated swelling of any bones or joints?

If answered yes to the above question, please circle which of the following is applicable

Head Neck Chest Shoulder Back Hand Wrist Elbow Forearm Hip Thigh Knee
Ankle Shin Calf Foot

IF YOU CHECK YES TO ANY OF THE QUESTIONS LISTED BELOW, PLEASE PROVIDE A COMPLETE EXPLANATION ON THE REVERSE SIDE OF THIS PAGE.

1. Do any of the injuries circled in the last question currently bother you?
2. Do you have any other medical problems such as asthma, mono, diabetes, etc?
3. Have you had any medical injuries or problems since your last medical evaluation?
4. Any special instructions or precautions the school and coaches should be aware of?
5. What was the date of your last tetanus shot? _____
6. Do you use any tobacco products?
7. **WOMEN ONLY** - Are you having irregular periods?

I/We hereby state that to the best of my/our knowledge, the answers are correct. I/we understand that by performing this examination, the undersigned physician does not assume responsibility for the medical care of this individual.

Athlete Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

Santa Cruz City Schools Athletic Clearance Packet

Harbor High Santa Cruz High Soquel High

405 Old San Jose Road, Soquel, California
95073 (831) 429-3410 www.sccs.net

Pre-Participation Physical

To Be Completed by Physician

Athlete's Name _____ Date _____

Height _____ Weight _____ BP _____/_____ Pulse Rate _____Vision: Right 20/ _____

Vision Left 20/_____ Corrected

Medical	Normal	Abnormal
Skin		
Eyes / Ears / Nose / Throat		
Lymph Nodes		
Heart		
Pulse		
Lungs		
Abdomen		
Genitalia (Males Only)		
Musculoskeletal	**Normal**	**Abnormal**
Neck		
Back		
Shoulder / Arm		
Elbow / Forearm		
Wrist / Hand		
Hip / Thigh		
Knee		
Leg		
Ankle / Foot		

_____ Cleared for All Activities ____ Not Cleared for All Activities Due to _____

Physician Name _____ Physician Signature _____ Date _____