C.I.F. ATHLETIC PARTICIPATION HEALTH FORM

SANTA BARBARA UNIFIED SCHOOL DISTRICT

HEALTH SERVICES

STUDENT INFORMATION to be completed by student-Parent signature **REQUIRED**

Name: _____

LAST FIRST

Address: _____

HISTORY:

1. Have you had—(**circle if YES**) allergies, asthma, seizures, heart murmur, a broken bone, diabetes, surgery or hospitalization: Explain_____

_____

2. Do you wear corrective lenses during sports? YES_____ NO_____
3. Is your hearing normal? YES_____ NO_____
4. Do you take any medications? YES_____ NO_____ If YES, what? _____
5. Please note any other medical information that school personnel may need to know: _____

_____

Parent/Guardian Permission for EXAM: _____DATE:_____

ORIGINAL MUST BE RETURNED TO SCHOOL-NO COPIES

PHYSICIAN INFORMATION – TO BE COMPLETED BY PHYSICIAN OR NURSE PRACTITIONER ONLY

PHYSICAL EXAMINATION

Height: _____ Weight: _____ BP:_____/_____ Pulse:_____

Code: 0 = Negative X = Positive NE: = No Examination

1. Ears, Nose, Throat		8. Musculoskeletal Evaluation	
2. Eyes—pupil equal reactive		8.1 Flexibility/stability of joints	
Symmetry of eye movement		Gait Hand	
3. Dental—Missing teeth		Kneebend	
Chipped teeth		8.2 Spine—scoliosis	
Removable teeth		8.3 Swelling of joints	
Orthodontia		8.4 Muscular Weakness	
4. Lungs		8.5 Atrophy	
5. Heart		Thigh Shoulder Girdle	
6. Abdomen		Calf Arm	
7. Hernia		9. Incoordination/loss of balance	

Additional findings, comments and/or recommendations: _____

_____

"I certify that I have on this date examined this student and that on the basis of the exam requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities."

IF STUDENT IS NOT MEDICALLY FIT TO PARTICIPATE IN ATHLETICS OR IF THERE ARE EXCEPTIONS TO THE ABOVE STATEMENT, EXAMINING PHYSICIAN SHOULD INDICATE ABOVE.

Signature of Examining Physician: _____ **Phone:** _____

Print Name: _____ **Date:** _____ **Agency:** _____