GARDEN GROVE UNIFIED SCHOOL DISTRICT
Preparticipation Physical Evaluation

PHYSICAL EVALUATION

Name_____Date of Birth_____Student ID #_____

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP ____/____ (____/____ , ____/____)

Vision R 20/____ L 20/____ Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS
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		

CLEARANCE:

☐ **Cleared for participation in competitive interscholastic athletics at the present time.**

☐ **Cleared for participation in competitive interscholastic athletics after completing evaluation/rehabilitation for:**

_____

_____

☐ **Not cleared for participation in competitive interscholastic athletics.**
Reason: _____

_____

Recommendations: _____

_____

_____

Name of Physician (print or type) _____ **Date** _____

Address _____ **Phone:** _____

Signature of Physician (*MD or DO only*) _____ **Medical License #** _____

Physician's Stamp: _____

_____

_____

_____

CIF.1 5/06
GGUSD Form #9802.170

GARDEN GROVE UNIFIED SCHOOL DISTRICT
Preparticipation Physical Evaluation

DATE OF PHYSICAL EVALUATION_____ Student ID#_____ Graduating Class of _____

Name:_____ Sex:_____ Age:_____ Date of Birth:_____

Grade_____ School:_____ Sport(s):_____

Address:_____ Phone:_____

Personal Physician:_____ Phone:_____

***In case of emergency, contact*:** Name_____ Relationship_____

Home Phone_____, Work Phone _____, Cell Phone_____

Explain "Yes" answers below. Circle yes or no to each question (circle question if you do not know the answer).

1. Have you had a medical illness or injury since your last check up or sports physical? ..... Yes No
   Do you have an ongoing or chronic illness? ..... Yes No

2. Have you ever been hospitalized overnight?..... Yes No
   Have you ever had surgery?..... Yes No

3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?..... Yes No
   Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? ..... Yes No

4. Do you have any allergies (i.e., to pollen, medicine, food, or stinging insects)?..... Yes No
   Have you ever had a rash or hives develop during or after exercise?..... Yes No

5. Have you ever passed out during or after exercise? ..... Yes No
   Have you ever been dizzy during or after exercise?..... Yes No
   Have you ever had chest pain during or after exercise?.... Yes No
   Do you get tired more quickly than your friends do during exercise?..... Yes No
   Have you ever had racing of your heart or skipped heartbeats? ..... Yes No
   Have you had high blood pressure or high cholesterol?.... Yes No
   Have you ever been told you have a heart murmur?..... Yes No
   Has any family member or relative died of heart problems or of sudden death before age 50?..... Yes No
   Have you had a severe viral infection (i.e., myocarditis, or mononucleosis) within the last month? ..... Yes No
   Has a physician ever denied or restricted your participation in sports for any heart problems?..... Yes No

6. Do you have any current skin problems (i.e., itching, rashes, acne, warts, fungus, or blisters)? ..... Yes No

7. Have you ever had a head injury or concussion?..... Yes No
   Have you ever been knocked out, become unconscious or lost your memory?..... Yes No
   Have you ever had a seizure? ..... Yes No
   Do you have frequent or severe headaches?..... Yes No
   Have you ever had numbness or tingling in your arms, hands, legs or feet?..... Yes No
   Have you ever had a stinger, burner, or pinched nerve?... Yes No

8. Have you ever become ill from exercising in the heat?.... Yes No

9. Do you cough, wheeze, or have trouble breathing during or after activity? ..... Yes No
   Do you have asthma?..... Yes No
   Do you have seasonal allergies that require medical treatment?..... Yes No

10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (i.e., knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?..... Yes No

11. Have you had any problems with your eyes or vision?..... Yes No
    Do you wear glasses, contacts or protective eyewear?.... Yes No

12. Have you ever had a sprain, strain, or swelling after injury?..... Yes No
    Have you broken or fractured any bones or dislocated any joints?..... Yes No
    Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?..... Yes No
    If yes, check and explain below:

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/Calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper Arm		☐ Foot

13. Do you lose weight regularly to meet weight requirements for your sport?..... Yes No

14. Do you feel stressed out?..... Yes No

Explain "Yes" answers here:_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. I hereby permit the above student to participate in competitive interscholastic sports and to receive the physical evaluation by my personal physician or a district approved medical practitioner.

Signature of student/athlete_____ **Date** _____

Signature of parent/guardian_____ **Date**_____