

**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
<b>MEDICAL</b>		
Appearance		
Eyes/Ears/Nose/ Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
<b>MUSCULOSKELETAL</b>		
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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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).**

- |  |   |                                    |                                |                              |                               |                                  |                                |                               |                                |                               |                                |                               |                                    |                                   |                                 |                                |                                    |  |                               |
|--|---|------------------------------------|--------------------------------|------------------------------|-------------------------------|----------------------------------|--------------------------------|-------------------------------|--------------------------------|-------------------------------|--------------------------------|-------------------------------|------------------------------------|-----------------------------------|---------------------------------|--------------------------------|------------------------------------|--|-------------------------------|
| <p>1. Have you had a medical illness or injury since your last check up or sports physical? ..... Yes No<br/>Do you have an ongoing or chronic illness? ..... Yes No</p> <p>2. Have you ever been hospitalized overnight?..... Yes No<br/>Have you ever had surgery?..... Yes No</p> <p>3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? ..... Yes No<br/>Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? ..... Yes No</p> <p>4. Do you have any allergies (i.e., to pollen, medicine, food, or stinging insects)? ..... Yes No<br/>Have you ever had a rash or hives develop during or after exercise? ..... Yes No</p> <p>5. Have you ever passed out during or after exercise? ..... Yes No<br/>Have you ever been dizzy during or after exercise?..... Yes No<br/>Have you ever had chest pain during or after exercise?.... Yes No<br/>Do you get tired more quickly than your friends do during exercise? ..... Yes No<br/>Have you ever had racing of your heart or skipped heartbeats? ..... Yes No<br/>Have you had high blood pressure or high cholesterol? .... Yes No<br/>Have you ever been told you have a heart murmur?..... Yes No<br/>Has any family member or relative died of heart problems or of sudden death before age 50?..... Yes No<br/>Have you had a severe viral infection (i.e., myocarditis, or mononucleosis) within the last month? ..... Yes No<br/>Has a physician ever denied or restricted your participation in sports for any heart problems?..... Yes No</p> <p>6. Do you have any current skin problems (i.e., itching, rashes, acne, warts, fungus, or blisters)? ..... Yes No</p> <p>7. Have you ever had a head injury or concussion?..... Yes No<br/>Have you ever been knocked out, become unconscious or lost your memory? ..... Yes No<br/>Have you ever had a seizure? ..... Yes No<br/>Do you have frequent or severe headaches?..... Yes No<br/>Have you ever had numbness or tingling in your arms, hands, legs or feet? ..... Yes No<br/>Have you ever had a stinger, burner, or pinched nerve? ... Yes No</p> | <p>8. Have you ever become ill from exercising in the heat? .... Yes No</p> <p>9. Do you cough, wheeze, or have trouble breathing during or after activity? ..... Yes No<br/>Do you have asthma?..... Yes No<br/>Do you have seasonal allergies that require medical treatment?..... Yes No</p> <p>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</p> <p>11. Have you had any problems with your eyes or vision?.....Yes No<br/>Do you wear glasses, contacts or protective eyewear?....Yes No</p> <p>12. Have you ever had a sprain, strain, or swelling after injury?.....Yes No<br/>Have you broken or fractured any bones or dislocated any joints?.....Yes No<br/>Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?.....Yes No<br/><i>If yes, check and explain below:</i></p> <table border="0"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/> Hip</td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Forearm</td> <td><input type="checkbox"/> Thigh</td> </tr> <tr> <td><input type="checkbox"/> Back</td> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/> Knee</td> </tr> <tr> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/> Shin/Calf</td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/> Finger</td> <td><input type="checkbox"/> Ankle</td> </tr> <tr> <td><input type="checkbox"/> Upper Arm</td> <td></td> <td><input type="checkbox"/> Foot</td> </tr> </table> <p>13. Do you lose weight regularly to meet weight requirements for your sport?.....Yes No</p> <p>14. Do you feel stressed out?.....Yes No</p> | <input type="checkbox"/> Head      | <input type="checkbox"/> Elbow | <input type="checkbox"/> Hip | <input type="checkbox"/> Neck | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh | <input type="checkbox"/> Back | <input type="checkbox"/> Wrist | <input type="checkbox"/> Knee | <input type="checkbox"/> Chest | <input type="checkbox"/> Hand | <input type="checkbox"/> Shin/Calf | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Finger | <input type="checkbox"/> Ankle | <input type="checkbox"/> Upper Arm |  | <input type="checkbox"/> Foot |
| <input type="checkbox"/> Head  | <input type="checkbox"/> Elbow  | <input type="checkbox"/> Hip       |                                |                              |                               |                                  |                                |                               |                                |                               |                                |                               |                                    |                                   |                                 |                                |                                    |  |                               |
| <input type="checkbox"/> Neck  | <input type="checkbox"/> Forearm  | <input type="checkbox"/> Thigh     |                                |                              |                               |                                  |                                |                               |                                |                               |                                |                               |                                    |                                   |                                 |                                |                                    |  |                               |
| <input type="checkbox"/> Back  | <input type="checkbox"/> Wrist  | <input type="checkbox"/> Knee      |                                |                              |                               |                                  |                                |                               |                                |                               |                                |                               |                                    |                                   |                                 |                                |                                    |  |                               |
| <input type="checkbox"/> Chest   | <input type="checkbox"/> Hand   | <input type="checkbox"/> Shin/Calf |                                |                              |                               |                                  |                                |                               |                                |                               |                                |                               |                                    |                                   |                                 |                                |                                    |  |                               |
| <input type="checkbox"/> Shoulder  | <input type="checkbox"/> Finger   | <input type="checkbox"/> Ankle     |                                |                              |                               |                                  |                                |                               |                                |                               |                                |                               |                                    |                                   |                                 |                                |                                    |  |                               |
| <input type="checkbox"/> Upper Arm   |   | <input type="checkbox"/> Foot      |                                |                              |                               |                                  |                                |                               |                                |                               |                                |                               |                                    |                                   |                                 |                                |                                    |  |                               |

**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 \_\_\_\_\_