

# 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: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Personal Physician/Provider: \_\_\_\_\_

**Explain "Yes" answers below.**

	Yes	No		Yes	No
1. Do you think you are in good health?	<input type="checkbox"/>	<input type="checkbox"/>	23. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an ongoing medical condition? (ex: diabetes or asthma)	<input type="checkbox"/>	<input type="checkbox"/>	24. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills?	<input type="checkbox"/>	<input type="checkbox"/>	25. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	26. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has a physician ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	27. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29. Have you had infectious mononucleosis within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
9. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	31. Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	32. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has a doctor ever ordered a test for your heart? Example: ECG, echocardiogram	<input type="checkbox"/>	<input type="checkbox"/>	33. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
12. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	34. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
13. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	35. Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
14. Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	36. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
15. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	37. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	38. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
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:	<input type="checkbox"/>	<input type="checkbox"/>	40. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	41. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
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:	<input type="checkbox"/>	<input type="checkbox"/>	42. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
Head   Neck   Shoulder   Upper Arm   Elbow   Chest   Hand/Fingers   Forearm			43. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Ankle   Foot/Toes   Upper Back   Lower Back   Hip   Thigh   Knee   Calf/Shin			44. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	45. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>	46. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
			47. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>

**FEMALES ONLY**

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:** \_\_\_\_\_

**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*
<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			

Date of last Tdap booster: \_\_\_\_\_ Varicella Documentation: \_\_\_\_\_

## CLEARANCE

- Cleared without restriction
- Cleared, with recommendations for further evaluation or treatment for: \_\_\_\_\_
- 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**