Palisades Charter High School
Sport Pre-participation Physical Examination and Health History

Male _____ Female _____
School Year: _____

Last Name: _____ First: _____ MI___ DOB: _____ Grade: _____ Sport(s): _____

Address/City/Zip: _____ Parent Phone: _____

Health History (completed by student & parent prior to physical exam): explain 'YES' answers; be specific, include approx. dates, current status

Heart Trouble	Yes	No	Asthma	Yes	No	Diabetes	Yes	No	Seizures	Yes	No
Palpitations	Yes	No	Fatigue	Yes	No	High Blood Pressure	Yes	No	Kidney conditions	Yes	No
Chest pain	Yes	No	Dizzy/fainting	Yes	No	Extreme shortness of breath/wheezing	Yes	No	Current skin condition	Yes	No
Family member w heart attack < 50 yrs of age, sudden death	Yes	No	Glasses, contacts, protective equipment, hearing aid	Yes	No	Head trauma, concussion, loss of consciousness	Yes	No	Family history of Marfan syndrome or sickle cell	Yes	No
Any allergies	Yes	No	Any injuries or fractures	Yes	No	Any surgeries or hospitalizations	Yes	No	Any other chronic condition	Yes	No

***Parent & student confirm that all of this information is correct and has been reviewed with the doctor during the examination. ***

List all medications for health conditions: _____

List all allergies(give reactions & meds) and/or asthma triggers: _____

Explain "YES" answers: _____

_____ _____ _____ _____
Student Signature Date Parent Signature Date

PHYSICAL EXAMINATION and review of HEALTH HISTORY (completed by the physician)

Distance Vision: R 20/___ L 20/ ___ corrected: Y N		**HT: _____ WT: _____ BMI/% _____BP: _____ Pulse: ____**	
	Normal		Normal
Appearance		Musculoskeletal	
Eyes/Ears/Nose/Throat		Neck	
Neck		Spine	
Cardiovascular		Shoulders/arms	
EKG results if done		Elbows/forearms	
Chest & Lungs		Wrist/hands	
Abdomen		Hips/thigh	
Skin		Knees	
Neuromuscular		Legs/ankles	
Genitalia – hernia (males)		Feet	

Diagnosed Chronic Conditions: _____

( ) Cleared - Full Activity ( ) Cleared – No management of chronic condition required during school or school sports

( ) Cleared - Chronic condition management required during school & school sports for _____Medication: *(use Pali med form)*

( ) Cleared with restrictions/end date: _____

( ) Cleared *after* proof of evaluation or rehab for: _____

( ) Not cleared/reason: _____

Comments: _____

PHYSICIAN STAMP REQUIRED

Physician Name_____ Physician's Original Signature: _____ Exam Date: _____