

BERKELEY UNIFIED SCHOOL DISTRICT
BERKELEY HIGH SCHOOL ATHLETIC DEPARTMENT

California Interscholastic Federation By-Laws state that an annual physical examination, or a statement by a medical practitioner, certifying that the student is physically fit to participate in athletics is required before a student may try out, practice, or participate in interscholastic athletic competition.

Annual Physical Examination for Participation in Athletics

PATIENT INFORMATION

Student's Name _____ Date _____
Address _____ Age _____
Student's Birth Date _____ Home Phone () _____
Father's Work Phone () _____ ext. _____
Mother's Work Phone () _____ ext. _____
Family Physician _____ Physician's Phone () _____
Physician's Address _____ City/ Zip _____
Hospital Preference _____
Family Dentist _____ Dentist's Phone () _____
Medical Insurance _____ Medical No. _____

MEDICAL HISTORY

1. Have you ever had any injuries such as:

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Skull Fracture	<input type="checkbox"/>	<input type="checkbox"/>	Heat Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Painful Kneecap
<input type="checkbox"/>	<input type="checkbox"/>	Concussion	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Shin splints
<input type="checkbox"/>	<input type="checkbox"/>	Knocked out	<input type="checkbox"/>	<input type="checkbox"/>	Severe Dehydration	<input type="checkbox"/>	<input type="checkbox"/>	Trick knee
<input type="checkbox"/>	<input type="checkbox"/>	Arm/finger numbness	<input type="checkbox"/>	<input type="checkbox"/>	Broken bone, fracture	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain/injury
<input type="checkbox"/>	<input type="checkbox"/>	Deep bruise	<input type="checkbox"/>	<input type="checkbox"/>	Joint dislocation	<input type="checkbox"/>	<input type="checkbox"/>	Back pain/injury
<input type="checkbox"/>	<input type="checkbox"/>	Muscle tear or pull	<input type="checkbox"/>	<input type="checkbox"/>	Internal organ injury	<input type="checkbox"/>	<input type="checkbox"/>	Ligament sprain
<input type="checkbox"/>	<input type="checkbox"/>	Locking or catching joint	<input type="checkbox"/>	<input type="checkbox"/>	Leg/foot numbness	<input type="checkbox"/>	<input type="checkbox"/>	Other

Explain: _____

2. Do you have a history of any medical problems such as:

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma, allergy	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Tightness in chest	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Seizures/fainting	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Heart palpitations
<input type="checkbox"/>	<input type="checkbox"/>	Yellow jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Visual impairment	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Skin disease, boils	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Cold sores
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell disease	<input type="checkbox"/>	<input type="checkbox"/>	High/low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising/bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Other

Explain: _____

1. Are you allergic to any medicines or environmental agents?

Yes No If Yes, explain: _____

2. Has anyone in your family under 50 years old died of heart problems or sudden unexplained causes?

Yes No If Yes, explain: _____

3. Have you ever been hospitalized?

Yes No If Yes, explain: _____

4. Have you ever had an operation or surgery?

Yes No If Yes, explain: _____

5. Have you ever had x-rays, worn a cast, splint or sling, or used crutches?

Yes No If Yes, explain: _____

6. Have you ever sustained an injury that prevented you from playing sports for more than one day?

Yes No If Yes, explain: _____

MEDICAL EXAMINATION

Date of Exam _____

Height _____

Weight _____

Urinalysis: _____ Blood PH _____

Blood Pressure _____

Eyes R 20/ _____

Eyes L 20/ _____

Ketone _____ SpG _____

Pulse _____

Glasses _____

Contacts _____

Glucose _____ Protein _____
Hematocrit _____

Normal	Abnormal	Medical Exam	Comments
<input type="checkbox"/>	<input type="checkbox"/>	1. General appearance (fitness, body fat)	_____
<input type="checkbox"/>	<input type="checkbox"/>	2. HEENT (pupils, ears, nose, mouth, teeth, throat)	_____
<input type="checkbox"/>	<input type="checkbox"/>	3. Chest (chest wall, breath sounds)	_____
<input type="checkbox"/>	<input type="checkbox"/>	4. Cardiac (pulse, rhythm, murmur)	_____
<input type="checkbox"/>	<input type="checkbox"/>	5. Abdomen (liver, spleen, masses)	_____
<input type="checkbox"/>	<input type="checkbox"/>	6. Genitourinary (hernia, testes)	_____
<input type="checkbox"/>	<input type="checkbox"/>	7. Skin (rash, jaundice)	_____
<input type="checkbox"/>	<input type="checkbox"/>	8. Neurologic (CNS, DTR's sensation)	_____
<input type="checkbox"/>	<input type="checkbox"/>	9. Other	_____

Normal	Abnormal	Musculoskeletal Exam	Comments
<input type="checkbox"/>	<input type="checkbox"/>	1. Spine (deformity, tenderness, motion, strength)	
<input type="checkbox"/>	<input type="checkbox"/>	a. Cervical	_____
<input type="checkbox"/>	<input type="checkbox"/>	b. Thoracic	_____
<input type="checkbox"/>	<input type="checkbox"/>	c. Lumbar	_____
<input type="checkbox"/>	<input type="checkbox"/>	2. Upper extremity (deformity, tenderness, motion, strength, stability)	
<input type="checkbox"/>	<input type="checkbox"/>	a. AC joint/clavicle	_____
<input type="checkbox"/>	<input type="checkbox"/>	b. Shoulder	_____
<input type="checkbox"/>	<input type="checkbox"/>	c. Elbow	_____
<input type="checkbox"/>	<input type="checkbox"/>	d. Wrist	_____
<input type="checkbox"/>	<input type="checkbox"/>	e. Hand	_____
<input type="checkbox"/>	<input type="checkbox"/>	3. Lower extremity (deformity, tenderness, motion, strength, stability)	
<input type="checkbox"/>	<input type="checkbox"/>	a. Hip	_____
<input type="checkbox"/>	<input type="checkbox"/>	b. Knee (MCL, ACL, PCL, menisci)	_____
<input type="checkbox"/>	<input type="checkbox"/>	c. Leg (hams, quads, gastroc)	_____
<input type="checkbox"/>	<input type="checkbox"/>	d. Ankle (talar tilt, drawer)	_____
<input type="checkbox"/>	<input type="checkbox"/>	e. Foot	_____

FINDINGS - Treatment Recommendations

Diagnosis:

1. _____
2. _____

DISPOSITION

- Cleared for collision, contact, and non-contact sports _____
- Conditional participation, limited to: _____
- No participation until: _____
- No participation in any sport, because of: _____

PHYSICIAN'S STATEMENT

I hereby certify that I (1) _____ have ; (2) _____ have not; found _____ (name of student) to be physically fit to participate in interscholastic high school sports, including tackle football.

Physician's Signature _____ Physician's Office Stamp

Date: _____

PARENT/GUARDIAN STATEMENT

I hereby state that the information given on this statement is true to the best of my knowledge.

Parent/Guardian Signature: _____ Date: _____