Sweetwater Union High School District

1130 Fifth Avenue, Chula Vista CA 91911 619-585-6015

Sports/Co-curricular Participation Screening Risk Assessment

STUDENT NAME: _____ BIRTHDATE: _____

SCHOOL: _____ GRADE: _____

SPORT(S): _____ GENDER: Male Female Non-Binary

ADDRESS: _____ HOME PHONE: _____

FATHER'S WORK PHONE: _____ FATHER'S CELL PHONE: _____

MOTHERS WORK PHONE: _____ MOTHER'S CELL PHONE: _____

FAMILY DOCTOR: _____ DOCTOR'S PHONE: _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

EMERGENCY CONTACT HOME/CELL PHONE: _____

MEDICAL HISTORY - Please answer the following questions regarding your student. Please explain "YES" answers below.

1	Has or had injuries requiring medical attention?	Yes	No
2	Has or had an illness requiring hospitalization?	Yes	No
3	Has or had coughing, wheezing, or trouble breathing during or after activity?	Yes	No
4	Has or had asthma?	Yes	No
5	Have had seasonal allergies that require medical treatment?	Yes	No
6	Are you currently taking any prescription or non-prescription (over the counter) medications or pills or using an inhaler?	Yes	No
7	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	Yes	No
8	Have you ever passed out during or after exercise that require medical treatment?	Yes	No
9	Have you ever been dizzy during or after exercise that require medical treatment?	Yes	No
10	Have you ever had chest pain during or after exercise that require medical treatment?	Yes	No
11	Have you ever had racing of your heart or skipped heartbeats that require medical treatment?	Yes	No
12	Have you ever been told you have a heart murmur?	Yes	No
13	Have you ever been told you have high blood pressure? *** NO CAFFINATED DRINKS 4 HOURS PRIOR TO SCREENING***	Yes	No
14	Has any family member or relative died of heart problems or of sudden death before age 55?	Yes	No
15	Has a physician ever denied or restricted your participation in sports for any heart problems?	Yes	No
16	Have you ever had a head injury or concussion, been knocked out, become unconscious, or lost your memory?	Yes	No
17	Have you ever had a seizure?	Yes	No
18	Do you have frequent or severe headaches that require medical treatment?	Yes	No
19	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	Yes	No
20	Have you ever had a stinger, burner, or pinched nerve?	Yes	No
21	Is hearing impaired, and/or has glasses/contact lenses? ****MUST BRING CONTACTS/GLASSES TO SCREENING****	Yes	No

Please explain any "YES" responses:_____

_____

_____

_____

_____

I have reviewed this medical history. In case of injury I hereby give consent for my son/daughter to have initial first aid administered by school personnel in charge and to be transported to a doctor or hospital for further treatment if necessary.

_____ _____

Parent/Guardian Signature **Date**

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Parent Consent

STUDENT NAME: _____ SCHOOL: _____

SPORT(S): _____ GENDER: Male Female Non-Binary

I hereby give my consent for my student _____ to be given a Sport/ Co-curricular Participation Screening Examination and (if indicated an EKG/ECHO CARDIOGRAM/ Baseline Concussion Testing) by a team of Sports Medicine Specialists (Orthopedic Surgeon, Family Practitioner, Certified Athletic Trainer and Physical Therapist).

_____ _____

Parent/Guardian Signature **DATE**

PHYSICAL EXAM

Height:	_____	**Weight:**	_____
Blood Pressure*:	_____	**Pulse:**	_____
Vision (R):	_____	**Vision (L):**	_____

	Normal	Abnormal	
Flexibility/Posture:			
ROM Screens:			**Blood Pressure RE-CHECK*:**
Upper Extremities	_____	_____	2nd _____
Lower Extremities	_____	_____	3rd _____
Scoliosis	**NO**	**YES**	

Comments: _____

ORTHOPEDIC EXAMINATION

Upper Extremities	Normal	Abnormal	Lower Extremities	Normal	Abnormal
Shoulder	_____	_____	**Hip**	_____	_____
Elbow	_____	_____	**Knee**	_____	_____
Wrist/Hand	_____	_____	**Ankle**	_____	_____
Spine	_____	_____	**Foot**	_____	_____

Comments: _____

ORTHOPEDIC DETERMINATION - In my opinion this student (please check one):

☐ **Is CLEARED for sports/co-curricular participation** ☐ **Is NOT-CLEARED for sports/co-curricular participation** ☐ **Ortho Deferred**

Ortho Physician: _____ **MD /DO** **Date of Physical:** _____

PHYSICAL EXAMINATION

	Normal	Abnormal		Normal	Abnormal	
Head & Neck	_____	_____	**Cardiovascular**	_____	_____	
Eyes	_____	_____	**Gastrointestinal**	_____	_____	**Female - Age of 1st menstrual cycle:**
Ears/Nose & Throat	_____	_____	**Genito-Urinary**	_____	_____	_____

Comments: _____

PHYSICIAN DETERMINATION In my opinion this student (please check one):

☐ **Is CLEARED for sports/co-curricular participation** ☐ **Is NOT-CLEARED for sports/co-curricular participation** ☐ **Medical Deferred**

Physician: _____ **MD /DO** **Date of Physical:** _____

EKG/ECHO REFERRAL: ☐ **Is CLEARED if EKG is within NORMAL limits.**

☐ **EKG completed & within NORMAL limits? YES NO** ☐ **Cardiac Deferred**

EKG/ ECHO Comments: _____

Comments on Medical History: _____

_____

_____

_____

NOTE: Hospital, Clinic or Doctor's Stamp REQUIRED