RIALTO UNIFIED SCHOOL DISTRICT
DEPARTMENT OF HEALTH SERVICES
SECONDARY SPORTS PHYSICAL EXAMINATION

Name_____Age_____Sex_____Date of Birth_____

Address_____Phone(___)_____

Grade_____Sport(s)_____

School_____Personal Physician_____Physician's Phone(___)_____

Please answer all questions before the time of your examination. Explain all "yes" answers in the space provided.

		Yes	No
1.	Are you currently under doctor's care for any reason?...	❑	❑
2.	Have you ever been hospitalized overnight?.....	❑	❑
3.	Have you ever had surgery?	❑	❑
4.	Are you currently taking any prescription or non prescription(over-the-counter) medications or pills or using an inhaler?.....	❑	❑
5.	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	❑	❑
6.	Do you have any allergies (pollen, medicine, food, or stinging insects)?,.....	❑	❑
7.	Have you ever had a rash or hives develop during or after exercise?.....	❑	❑
8.	Have you ever been dizzy or passed out during or after exercises?.....	❑	❑
9.	Have you ever had chest pain during or after exercise?	❑	❑
10.	Do you get tired more quickly than your friends do during exercise?.....	❑	❑
11.	Have you ever had high blood pressure or high cholesterol?.....	❑	❑
12.	Have you ever been told that you have a heart murmur?	❑	❑
13.	Have you ever had racing of your heart or skipped heart-beats?.....	❑	❑
14.	Has any of your family died of heart problems or sudden death before age 50?.....	❑	❑
15.	Has a physician ever denied or restricted your participation in sports for any heart problems?.....	❑	❑
16.	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?...	❑	❑
17.	Have you ever had a head injury or concussion?.....	❑	❑
18.	Have you ever been knocked out, become unconscious, or lost your memory?.....	❑	❑
19.	Have you ever had a seizure?.....	❑	❑
20.	Do you have frequent or severe headaches?.....	❑	❑
21.	Have you ever had numbness or tingling in your arms, hands, legs, or feet?.....	❑	❑
22.	Have you ever had a stinger, burner, or pinched nerve?.	❑	❑
23.	Have you ever become ill from exercising in the heat?..	❑	❑
24.	Have you ever been dizzy or passed out in the heat?.....	❑	❑
25.	Do you have any trouble breathing or do you cough, wheeze or have trouble breathing during or after exercise?.....	❑	❑
26.	Do you have asthma?.....	❑	❑

		Yes	No
27.	Do you use any special equipment (braces, neck rolls, mouth guards).....	❑	❑
28.	Do you have any seasonal allergies that require medical treatment?.....	❑	❑
29.	Do you have any current skin problems (itching, rashes, acne, warts, fungus, or blisters?).....	❑	❑
30.	Have you ever had an eating disorder?.....	❑	❑
31.	Have you ever had any problems with your eyes or vision?.....	❑	❑
32.	Do you wear glasses or contacts or protective eye wear?.....	❑	❑
33.	Do you have only one working organ of usually paired organs (only one eye, kidney, etc.?).....	❑	❑
34.	Have you ever sprained, broken, dislocated or had repeated swelling or pain of any bones or joints?.....	❑	❑
	❑ head ❑ neck ❑ chest ❑ shoulder ❑ back ❑ hand ❑ wrist ❑ elbow ❑ forearm ❑ hip ❑ thigh ❑ knee ❑ ankle ❑ shin/calf ❑ foot ❑ finger ❑ upper arm		
35.	Have you had any problems or injuries since your last medical evaluation?.....	❑	❑
36.	Do you want to weigh more or less than you do now?..	❑	❑
37.	Do you lose weight regularly to meet weight requirements for your sport?.....	❑	❑
38.	Do you feel stressed out?.....	❑	❑

39. Record the dates of your most recent immunization shots for:
Tetanus_____ Measles_____
Hepatitis B_____ Chickenpox_____

FEMALES ONLY

40. When was your first menstrual period?_____
Date of last menstrual period_____
What was the longest time between your periods during the past year?_____

*EXPLAIN ALL 'YES' ANSWERS BY QUESTION NUMBER:*_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

_____ Date_____

Signature of Athlete

_____ Date_____

Signature of Parent/Guardian (if athlete is under 18 years of age)

SS-1 (Revised 7/04)

DO NOT WRITE BELOW THIS LINE - FOR PHYSICIAN'S USE ONLY

Name_____ Date of Birth_____

Height _____ Weight _____ Pulse_____BP_____/_____(__ _____/_____, _____/_____)

Vision: R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (Males Only)			
Skin			

MUSCULOSKELETAL

Neck			
Back			
Shoulder/Arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

CLEARANCE

❑ **Cleared**

❑ **Cleared after completing evaluation/rehabilitation for:** _____

_____

_____

❑ **Not cleared for:** _____ **Reason:** _____

Recommendations: _____

_____

_____

_____

Name of Physician (print/type) _____ **Date** _____

Address_____ **Phone #** _____ **Fax#** _____

Signature of Physician _____, **MD or DO**