



NAPA VALLEY UNIFIED SCHOOL DISTRICT SPORTS PHYSICAL EXAMINATION FORM

PART 1 (TO BE COMPLETED BY A PARENT OR LEGAL GUARDIAN)

LAST NAME		FIRST NAME			GRADE
BIRTHDATE	FALL SPORT	WINTER SPORT	SPRING SPORT	STUDENT ID NUMBER	

PART 1 -- HEALTH HISTORY (Must be Completed by Parent/Guardian Prior to the Examination)

	Yes	No		Yes	No	
1.	<input type="checkbox"/>	<input type="checkbox"/>	Has this student had: Chronic or recurrent illness?	<input type="checkbox"/>	<input type="checkbox"/>	Injuries requiring medical care or treatment?
2.	<input type="checkbox"/>	<input type="checkbox"/>	Illness lasting over 1 week?	<input type="checkbox"/>	<input type="checkbox"/>	Neck or back pain or injury?
3.	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalizations or Surgeries?	<input type="checkbox"/>	<input type="checkbox"/>	Knee pain or injury?
4.	<input type="checkbox"/>	<input type="checkbox"/>	Nervous, psychiatric, or neurologic condition?	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder or elbow pain or injury?
5.	<input type="checkbox"/>	<input type="checkbox"/>	Loss or nonfunctioning of organs (eye, kidney, liver, testicle) or glands?	<input type="checkbox"/>	<input type="checkbox"/>	Ankle pain or injury?
6.	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (medicines, insect bites, food)?	<input type="checkbox"/>	<input type="checkbox"/>	Other joint pain or injury?
7.	<input type="checkbox"/>	<input type="checkbox"/>	Problems with heart or blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones (fractures)?
8.	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain or significant or severe shortness of breath during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Does this student presently: Wear eyeglasses or contact lenses?
9.	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting with exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Wear dental bridges, braces or plates?
10.	<input type="checkbox"/>	<input type="checkbox"/>	Fainting, bad headaches or convulsions?	<input type="checkbox"/>	<input type="checkbox"/>	Take any medications? (List below):
11.	<input type="checkbox"/>	<input type="checkbox"/>	Potential concussion or loss of consciousness?	<input type="checkbox"/>	<input type="checkbox"/>	Further history: Birth defects (corrected or not)?
12.	<input type="checkbox"/>	<input type="checkbox"/>	Heat exhaustion, heatstroke, or other problems managing or responding to heat?	<input type="checkbox"/>	<input type="checkbox"/>	Death of a parent or grandparent less than 40 years of age due to medical cause or condition?
13.	<input type="checkbox"/>	<input type="checkbox"/>	Racing heartbeat, skipped or irregular heartbeats, or heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	Parent or grandparent requiring treatment for heart condition less than 50 years of age?
14.	<input type="checkbox"/>	<input type="checkbox"/>	Seizures or seizure disorders?	<input type="checkbox"/>	<input type="checkbox"/>	Been seen by a physician on an emergency or urgent basis in the last 12-months?
15.	<input type="checkbox"/>	<input type="checkbox"/>	Severe or repeated instances of muscle cramps?			

Date of last known tetanus (lockjaw) shot: _____

Date of last complete physical examination: _____

Explain all "YES" answers. Describe any other fact that should be disclosed prior to the examination (use reverse of form if needed):

PARENT/GUARDIAN'S AUTHORIZATION: I authorize the health care provider to perform a Sports Physical Evaluation on the student. The information set forth above is complete and accurate. I presently know of no reason why the student cannot fully and safely participate in the listed sports. For Sports Physical Evaluations that may be performed by District volunteers, I understand the evaluation is a screening evaluation only, and that I must address all health care concerns with the Student's personal physician or health care provider.

PRINT NAME OF PARENT OR GUARDIAN		SIGNATURE OF PARENT OR GUARDIAN		
ADDRESS	WORK PHONE	HOME PHONE	DATE	
REGULAR PHYSICIAN'S NAME	OFFICE PHONE			

PART 2 – MEDICAL EVALUATION (TO BE COMPLETED BY THE EXAMINING HEALTH CARE PROVIDER)

This Evaluation Can Only be Performed by Medical Doctors (MDs), Doctors of Osteopathy (DOs), Physician's Assistants (P.A.s), and Nurse Practitioners (N.P.s)

	NORMAL	ABNORMAL (Describe)	(May be contained on Provider's Form)
Eyes/Ears/Nose/Throat			Height: Weight:
Heart, lungs, pulmonary function			Pulse: After Ex:
Abdomen, genital/hernia (males)			BP:
Skin and Musculoskeletal:			Recommendation: <input type="checkbox"/> Unlimited participation <input type="checkbox"/> Limited participation/specific sports, events or activities <input type="checkbox"/> Clearance withheld pending further testing/evaluation <input type="checkbox"/> No athletic participation One of the above MUST be checked.
a. Neck/Spine/Shoulders/Back			
b. Arms/Hands/Fingers			
c. Hips/Thighs/Knees/Legs			
d. Feet/Ankles			
Neurologic Screening Exam (NSE)/			
Concussion Screening Evaluation (only if needed based on above info.)			
Comments:			
PRINT NAME OF PHYSICIAN	PHYSICIAN'S SIGNATURE		DATE