

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: _____
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: \_\_\_\_\_

**Palisades Charter High School**  
**Request For Any OTC or RX Medication To Be Taken At School**  
**PCHS Health Office (HO): 310 230-7218 Fax: 310 230-7246**

**I. Section To Be Completed By Parent:**

Student's Last Name	First Name	DOB	School Year	GR	Sport(s)
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- I understand I must provide any over-the-counter (OTC) or prescription (RX) medications as prescribed by doctor:
  - In its original container with proper labels; over-the-counter or prescription.
  - An updated doctor's order if there is a change in dosage, schedule or health status.
  - Student may not carry OTC or RX medications, except Health Office (HO) approved.
  - Parent must pick up unused medications by last day of school, if not; the medications will be disposed of properly.
- With doctor's orders and HO approval, my student may carry and self-administer without adult supervision but must follow MD orders. School Nurse must authorize any request to carry meds, i.e.: inhalers, epipen, insulin. I understand, accept there is no direct monitoring; student must alert staff for help. PCHS not responsible for any risk involved with improper use including: overuse, improper administration, breakage, theft, or loss. Health Office and/or Dean of Discipline will rescind consent if found to be sharing, playing or being careless with this medication.
  - Back-up meds in HO? Y/N . Health Office Approval to carry: \_\_\_\_\_
- **List All Triggers of:**  
**Allergies SEVERE:** \_\_\_\_\_  
  
**Allergies MILD/MODERATE:** \_\_\_\_\_  
  
**List Triggers of Asthma:** \_\_\_\_\_
- I consent to the PCHS School Nurse (or designee) communicating with the physician.
- I acknowledge that School Nurse (or designee) must authorize this order; student is given copy of orders when ok'd.

Print Parent Name	Signature	Date	Phone(s)	E-mail
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**II. Section To Be Completed By Physician:**

Medication	Purpose/Diagnosis	Dosage	Time at School Or Frequency	End Date

Special instructions, side effects, recommending HO back-up supply? \_\_\_\_\_

\_\_\_ May repeat rescue inhaler every 20 minutes times (\_\_\_), call parent, then 911 if needed Yes \_\_\_ No \_\_\_ I agree this student may carry inhaler, is capable and responsible.

Physician Stamp Required

Physician Printed Name/	Signature	Date
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This request expires at the end of the school year in which made. New doctor orders required each new school year.  
 See Administration of OTC & RX Medication in PCHS Parent/Student Handbook and applicable CEC.