FALLBROOK UNION HIGH SCHOOL
Athletic Participation Health Form

Student Name:_____ Student #:_____ DOB: _____ Grade:_____Sex:_____

Sports of Interest: .____2.____3.____4.____

This section to be filled out by parent guardian before seeing physician

I. EMERGENCY MEDICAL INFORMATION

_____Asthma _____Diabetes _____ Fainting _____Heart Condition
_____Epilepsy/Seizures _____ Bleeding Disorder _____Other
Allergic to: _____Foods _____Insects _____Medication _____Animals
If yes to any above, please explain:_____
_____

II. MEDICAL HISTORY

Are you:
Aware of any health problems/conditions?_____
Taking any medications?_____
Under medical care?_____

HAVE YOU EVER HAD OR CURRENTLY HAVE:

YES/NO
___/___Serious Injury_____
___/___Serious Illness_____
___/___Surgery_____
___/___Hospitalization_____
___/___Concussion_____
___/___Heart Murmur_____
___/___ Enlarged Heart_____
___/___ Marfan syndrome_____
___/___ Relatives with heart problems_____
___/___ Relatives die from hearth problems before 50_____
___/___Chest pain with exercise_____
___/___Dizziness/Fainting with exercise_____
___/___ High blood pressure_____
___/___Heat Illness_____
___/___ Neck/Spine Injury_____
___/___ Serious joint/bone injury_____
___/___Pneumonia/Mononucleosis_____
___/___Anemia/Sickle Cell_____
___/___Hernia/Appendicitis_____
___/___Birth defect_____
___/___Eye/Ear problems_____
___/___ Nose/Throat problems_____
___/___Respiratory/Lung problems_____
___/___ Kidney/Urinary problems_____
___/___ Stomach/Gastrointestinal problems_____
___/___ Dental problems_____

III. PARENTAL STATEMENT

Has it ever been necessary to restrict student's activities for medical reasons?
____YES ____NO
Is the student taking regular medication? ___YES ___NO
Does the student require special care/attention ___YES ___NO
EXPLAIN:_____
_____
_____

All students needing medication/s** during school hours and/or after school hours including practices, games, and all school activities must have a **written order form from their physician with the orders for the medication on file with the nurse in the Health office or the Athletic Trainer in the Athletic Training Room.**. A new form must be completed upon entering FUHS **and** at the beginning of each school year. Forms are available in the Health Office.

I understand that the short and basic sports physical examination has been given with the understanding that a complete and correct medical history has been provided. If the student is known to have any health or medical condition of any nature or type, I understand it is my responsibility to assure that the doctor will be advised of the condition during the examination. I also understand it is my responsibility to determine together with the student's family physician whether a comprehensive medical examination should be undertaken by the student's family physician to approve the student's participation in athletics. To the best of my knowledge, the information given is accurate and complete. I provide my consent for my son/daughter to have an athletic physical examination and fully participate in interscholastic athletics subject to limitations noted. I understand I will be required to provide proof of medical insurance and pay (or petition waiver of) a transportation fee if my son/daughter is a member of an athletic team.

Parent/Guardian Signature_____

Date:_____

THIS SECTION TO BE COMPLETED BY HEALTHCARE PROFESSIONAL

IV. A. HEALTH EXAMINATION

HT:_____ WT:_____ BP:_____

Pulse:_____PERL:_____Glasses/Contacts:_____

B. To be completed by MD/DO/NP/PA

Please insist the applicant complete medical history. The student will be participating in strenuous activity that will include athletic competition. After completing this section please summarize any restrictions and/or necessary recommendations or follow-ups and sign.

Check if normal, circle if abnormal and explain:

_____Growth/Development _____Oral/Pharynx _____ Lungs/Respiratory
_____Heart/Cardiovascular _____Skin _____ Eyes/Ears/Nose
_____Head/Neck/Thyroid _____ Neurological _____ Abdomen/Hernia
_____Gastrointestinal _____ Musculoskeletal

Comments:_____
_____
_____
_____

V. PHYSICIAN'S EVALUATION

Approved for participation in interscholastic athletics:

YES:_____ NO_____ YES with CONDITIONS_____

SPECIFIC EXEMPTIONS, RECOMMENDATIONS, RESTRICTIONS:_____
_____
_____
_____

SIGNED:_____
(MD/DO/NP/PA)

DATE:_____