C.I.F. ATHLETIC PARTICIPATION HEALTH FORM

LAS VIRGENES UNIFIED SCHOOL DISTRICT

HEALTH SERVICES

C H S A T H L E T I C S

STUDENT INFORMATION *– To be completed by student – Parent/Guardian signature required*

Last name:	*First name:*

HISTORY: (check yes or no)

YES	***NO***	***ILLNESS***	***YES***	***NO***	***ILLNESS***	***YES***	***NO***	***ILLNESS***
		Allergy/Asthma			*Glasses/Contacts*			*Mononucleosis*
		Arthritis			*Heart Murmur*			*Mumps*
		Chicken Pox			*Hepatitis*			*Pneumonia*
		Concussion			*Hernia*			*Polio*
		Diabetes			*Kidney problems*			*Rheumatic fever*
		Epilepsy/Seizures			*Measles*			*Tuberculosis*
		Fainting (frequent)			*Migraine headache*			*Whooping coup*

1. *Please note any other medical information that school personnel may need* _____

_____

ORIGINAL MUST BE RETURNED TO SCHOOL – NO COPIES

PHYSICIAN INFORMATION – To be completed by Physician or Nurse Practitioner only.

t:	***Weight:***	***B.P.***	***Pulse:***

Code: 0 – Negative ***X = Positive*** ***NE: = No Examination***

Ear, Nose, Throat		*8. Musculoskeletal evaluation*	
Eyes – pupil equal reactive		*8.1 Flexibility/stability of joints*	
- *Symmetry of eye movement*		*- Gait - hand*	
Dental – missing teeth		*- Knee bend*	
- *chipped teeth*		*8.2 Spine: Scoliosis*	
- *removable teeth*		*8.3 Swelling of any joint*	
- *orthodontia*		*8.4 Muscular weakness*	
Lungs		*8.5 Atrophy*	
Heart		*- Thigh -shoulder girdle*	
Abdomen		*- Calf -arm*	
Hernia		*9. In coordination/loss of balance*	

Additional findings, comments and /or recommendations _____

_____

"I certify that I have on this date examined this student and that, on the basis of the exam requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities."

IF STUDENT IS NOT MEDICALLY FIT TO PARTICIPATE IN ATHLETICS OR IF THERE ARE EXCEPTIONS TO THE ABOVE STATEMENT, EXAMINING PHYSICIAN SHOULD INDICATE ABOVE.

Signature of Examining Physician: _____Phone: _____

Print Name: _____ Date of Physical: _____ Date: _____

(Good for one calendar year)

*OFFICE

*STAMP REQUIRED HERE

Please note: Physical done by school doctors at the annual school-wide physicals do not replace your child's regular annual check-up with your primary care physician.