

**MADERA UNIFIED SCHOOL DISTRICT
FAMILY HISTORY AND PHYSICAL FORM**

SPORT _____

Student's Name _____ ID # _____
LAST NAME FIRST NAME

What school did you attend last year? _____ Grade _____ Age _____ Date of Birth ____/____/____

Address _____ Phone _____

1. Have you had a medical illness or injury since your last check up or sports physical? YES NO
 Do you have an ongoing or chronic illness? YES NO
2. Have you ever been hospitalized overnight? YES NO
 Have you ever had surgery? YES NO
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? YES NO
 Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? YES NO
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? YES NO
 Have you ever had a rash or hives develop during or after exercise? YES NO
5. Have you ever passed out during or after exercise? YES NO
 Have you ever been dizzy during or after exercise? YES NO
 Have you ever had chest pain during or after exercise? YES NO
 Do you get tired more quickly than your friends do during exercise? YES NO
 Have you ever had racing of your heart or skipped heartbeats? YES NO
 Have you ever been told you have a heart murmur? YES NO
 Has any family member or relative died of heart problems or of sudden death before age 50? YES NO
 Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? YES NO
 Has a physician ever denied or restricted your participation in sports for any heart problems? YES NO
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? YES NO
7. Have you ever had a head injury or concussion? YES NO
 Have you ever been knocked out, become unconscious, or lost your memory? YES NO
 Have you ever had a seizure? YES NO
 Do you have frequent or severe headaches? YES NO
 Have you ever had numbness or tingling in your arms, hands, legs, or feet? YES NO
 Have you ever had a stinger, burner, or pinched nerve? YES NO
8. Have you ever become ill from exercising in the heat? YES NO
9. Do you cough, wheeze, or have trouble breathing during or after activity? YES NO
 Do you have asthma? YES NO
 Do you have seasonal allergies that require medical treatment? YES NO

10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? YES NO
11. Have you had any problems with your eyes or vision? YES NO
 Do you wear glasses, contacts, or protective eyewear? YES NO
12. Have you ever had a sprain, strain, or swelling after injury? YES NO
 Have you broken or fractured any bones or dislocated any joints? YES NO
 Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? YES NO

If yes, circle appropriately and explain below.

Head	Elbow	Hip
Neck	Forearm	Thigh
Back	Wrist	Knee
Chest	Hand	Shin/Calf
Shoulder	Finger	Ankle
Upper arm		Foot

13. Do you want to weigh more or less than you do now? YES NO
 Do you want to lose weight regularly to meet weight requirements for your sport? YES NO
14. Do you feel stressed out? YES NO
15. Record the dates of your most recent immunizations (shots) for:
 Tetanus _____ Measles _____
 Hepatitis B _____ Chickenpox _____

FEMALES ONLY

16. When was your first menstrual period? _____
 When was your most recent menstrual period? _____
 How much time do you usually have from the start of one period to the start of another? _____
 How many periods have you had in the last year? _____
 What was the longest time between periods in the last year? _____
Explain "YES" answers here: _____

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

➔ **SIGNED:** _____ **DATE:** _____ ➔ **SIGNED:** _____ **DATE:** _____
(Parent or legal guardian) (Student)

PHYSICAL EXAMINATION

LIABILITY WAIVER: I agree to indemnify and hold the physician named below harmless against responsibility for injuries or illness incurred by my student-athlete while participating in athletics.

➔ **Parent/Guardian Signature:** _____ **Date:** _____

BP ____/____ (____/____/____/____) Urine _____ Pulse _____

All students participating in athletics must have a physical examination. I hereby certify that I have examined _____ and found him/her to be physically fit to engage in sports.

STUDENT'S NAME

Notes:

Physician's Signature: _____ Date: _____