

FALLBROOK UNION HIGH SCHOOL
Athletic Participation Health Form

Student Name: _____ Student #: _____ DOB: _____ Grade: _____ Sex: _____

Sports of Interest: 1. _____ 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: _____

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

DATE: _____