ROSEVILLE JOINT UNION HIGH SCHOOL DISTRICT

Health History Questionnaire and Physical Exam

I. HEALTH HISTORY: *This form is to be completed by student and parent prior to physical exam*

Name:	DOB:	Sex:
School:	Grade:	Sport(s):

MEDICATIONS *Please list all of the prescription and over-the-counter medications that you are currently taking (Include inhalers, vitamins, supplements and herbal remedies)* _____

_____

ALLERGIES Do you have any allergies? □No □Yes	If yes, please identify specific type: □Food □Insect stings □Medicine □Pollen □Other
Date of Last Tetanus Immunization (required every 10 years):	

GENERAL HEALTH ***Explain "Yes" answers in the space provided at the bottom of the page***

Have you ever had or do you currently have any of the following:	**YES**	**NO**
Head injury, concussion, loss of consciousness during exercise?		
Back or neck problems, curvature of the spine, corrective orthopedic devices?		
Problems with foot, knee or other joints?		
Numbness, tingling in extremities, pinched nerve?		
Sprain, strain or other muscle injury?		
Broken or fractured bones, dislocated joints?		
Diabetes, hypoglycemia or excessive thirst?		
Lung problems, asthma, allergies, wheezing with exercise?		
Anemia, leukemia or any type of blood disorder		
Seizures, epilepsy?		
Headaches, dizziness or fainting spells		
Enlarged spleen or liver?		
Chronic viral infection?		
Eczema, hives, rashes, MRSA or other skin problems?		
Mental illness?		
Drug and/or alcohol addiction?		
Kidney issues, hernia or testicle problems?		
Eye injury, eye surgery, eye disease?		
Wear glasses, contacts, hearing aids, dentures or dental appliances (bracer, retainer)		
Eating disorder, unexplained weight loss/gain, other weigh issues?		
Heat exhaustion, heat stroke or other heat related illness?		
Any other chronic health conditions not already mentioned?		
Been hospitalized or had surgery within the past year?		
Do you know of any reason why you should not participate in sports?		
HEART HEALTH		
Has a doctor ever told you that you have a murmur, high blood pressure, rheumatic fever, heart infection or other heart problem?		
Have you ever passed out, been dizzy, or had chest pain while exercising?		
Have you ever had racing of your heart or skipped heartbeats?		
Has any family member died of heart problems or had an unexpected sudden death before the age of 50?		
Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?		

Explain "YES" answers here: _____

_____

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

Student signature_____ Parent/Guardian signature_____ Date_____

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Health History Questionnaire and Physical Exam

II. PHYSICAL EXAM

Student Name: _____ **DOB:** _____

Height:	Weight:	Pulse:	BP:
MEDICAL	**Normal**	**Abnormal**	
General Appearance			
Eyes/Ears/Nose/Teeth			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Hernia (males only)			
Menses (females only)			
Neurological			
Skin			
MUSCULOSKELETAL	**Normal**	**Abnormal**	
Neck			
Back/Spine			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Feet/toes			

□Cleared for full participation

□Not cleared for participation

□Able to participate with the following limitations: _____

Recommendations/Comments: _____

I have examined the above-named student and completed the pre-participation physical evaluation.

Licensed Healthcare Practitioner Signature_____ Date_____

PHYSICIAN'S CLEARANCE – Physician/Medical Facility Official Stamp/Name/Date is Required on this form or attach separate medical form/letter from medical office.

CIF requires clearance by MD or DO only.