

MBUSD – Mira Costa High School

Pre-participation Physical Evaluation

Female ___ Male ___
Year 2020-2021

Print Last Name _____ First Name _____ Middle Initial _____ Date of Birth _____ Grade _____ Sport _____

Address _____ City _____ Zip _____ Home Phone Number _____

Did you transfer from another high school? Yes No If yes, list date, name, city and state of last high school attended.

Father/Guardian's Name _____ Father/Guardian's Phone Number _____ Mother/Guardian's Name _____ Mother/Guardian's Phone No. _____

Father's Work Number _____ Mother's Work Number _____ Others to Call in Emergency (Name and Phone Number) _____

HEALTH HISTORY (To be completed by student & parent): Check "yes" or "no" and give as much information as possible.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Palpitations | <input type="checkbox"/> Yes <input type="checkbox"/> No Fatigue | <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Chest Pain |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Current Skin Condition | <input type="checkbox"/> Yes <input type="checkbox"/> No Dizziness/Fainting | <input type="checkbox"/> Yes <input type="checkbox"/> No Extreme Shortness of Breath/Wheezing | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No History of family member with heart attack under 50yrs of age or sudden death. | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Other: Glasses/Contacts, Protective Equipment, or Hearing Aid | <input type="checkbox"/> Yes <input type="checkbox"/> No Head Trauma/Loss of Consciousness | | |

Other: _____

History of any previous injuries, fractures, serious illnesses or operations/hospitalizations (describe and give approximate dates)

Current medications _____ Allergies _____ Date of Last Tetanus Shot _____

PARENT CONSENT

I hereby state that the above information is true and correct and give my consent for the above-named student to compete in sports and go with a representative of the school on any trips. In case of injury, the school representative is authorized to have him/her treated.

▶ _____ ▶ _____ ▶ _____ ▶ _____
Date Parent/Guardian Signature Name of Insurance Co. Policy/Group No.
+++++

PHYSICAL EXAMINATION (To be completed by physician):

Visual Acuity (Distance): O.D. _____ / _____ O.S. _____ / _____ () Corrected () Uncorrected
Height _____ Weight _____ Blood Pressure _____ Pulse _____

	Normal		Normal
1. Eyes, Ears, Nose, Throat		9. Musculoskeletal	
2. Neck		Neck	
3. Cardiovascular		Spine	
EKG results (if done)		Shoulders	
4. Chest and Lungs		Arms/Hands	
5. Abdomen		Hips	
6. Skin		Thighs	
7. Genitalia-Hernia (male)		Knees	
8. Neuromuscular		Ankles	
		Feet	

Comments: _____

RECOMMENDATION: () Full Activity – No restrictions () Activity with restrictions: _____
() No contact sports () No Participation
() Other _____

EXAMINING PHYSICIAN: _____ **DATE OF EXAM:** ▶ _____
Print name: ▶ _____ Signature: ▶ _____
LICENSE #: ▶ _____ Print or Stamp Address: ▶ _____ Phone: ▶ _____