

Coronado High School Sailing Team Health Forms

Name of Student _____ Age _____ Date of Birth _____

Grade Level _____ Sports: Fall _____ Winter _____ Spring _____

Family Doctor _____ Doctor phone nbr _____

	Yes	No
1 Has student ever been hospitalized?		
2 Has student ever had surgery?		
3 Does student have chronic illness for which regular doctor visits are required?		
4 Has student experienced unexpected weight loss?		
5 Has student experienced a medical problem or surgery since last physical exam?		
6 Is student presently taking any medication or pills?		
7 Does student have any allergies, including insect sting or medications?		
8 Has student ever passed out or felt dizzy during or after exercise?		
9 Has student ever had chest pain during or after exercise?		
10 Does student tire more quickly than friends during exercise?		
11 Does student have history of high blood pressure?		
12 Has student ever been told of any heart murmur condition?		
13 Does student have any history of heart skipping or racing?		
14 Has anyone in the student's family died suddenly or of heart problems before age of 50?		
15 Does student have any skin problems, itching, rashes, acne, eczema?		
16 Has student ever had a head injury or concussion?		
17 Has student ever been knocked out or unconscious?		
18 Has student ever experienced a seizure?		
19 Has student ever experienced a stinger or pinched nerve?		
20 Has student ever had muscle cramps or heat related cramps?		
21 Has student ever passed out or been dizzy because of heat?		
22 Does student cough or have trouble breathing during or after exercise?		
23 Does student have asthma?		
24 Does student require any special equipment, pads, braces, mouth or eye guards?		
25 Does student have trouble with vision or eye related conditions?		
26 Does student wear glasses, contacts, or protective eye wear?		
27 Has student fractured, dislocated or repeatedly sprained any bone or joint?		
28 Does student have any infectious condition, like mononucleosis?		
29 Is student diabetic?		
30 When was student's last tetanus shot?		
31 When was student's last measles immunization?		
For any yes indications, please write the question number here _____ and explain (use back of form if needed)		

For any yes indications, please write the question number here _____ and explain (use back of form if needed)

The information on this form, to the best of my knowledge, is accurate and inclusive of all related medical history of my child.

Parent/Guardian _____ Date _____

Primary contact for any follow up questions Phone _____ email _____

Coronado High School Sailing
Physical Exam Form 2014/15 Required form 2 of 3

ATHLETIC PHYSICAL EXAM FORM
(to be completed by physician)

Athlete's Name _____ Age _____ Date of Birth _____ Sex _____
Grade Level _____ Sport (s) _____
Height _____ Weight _____ Blood Pressure _____ / _____ Pulse _____
Vision: Right 20/ _____ Left 20/ _____ Corrected: Y N Pupils _____

	NORMAL (✓)	ABNORMAL FINDINGS
Cardiopulmonary		
Pulses		
Heart		
Lungs		
Genitalia (optional)		
Tanner stage 1 2 3 4 5 (circle one)		
Skin		
Abdominal		
Musculoskeletal		
Neck		
Shoulder		
Elbow		
Wrist		
Hand		
Back		
Knee		
Ankle		
Foot		
Other		

CLEARANCE (check ✓ one)

☐ CLEARED without limitations

☐ CLEARED with the following limitations:

☐ No Collision ☐ No Contact ☐ No Extreme Strenuous ☐ No Moderate Strenuous

Due to: _____

Recommendation: _____

☐ CLEARANCE DEFERRED until completing evaluation or rehabilitation for: _____

Examining Physician's Name _____ Date _____

Address _____ Phone _____

Parent Signature _____ Date _____

Please include primary email address:

Coronado High School Sailing
Physical Exam Form 2014/15 Required Form 3 of 3

General info

Student last name	First Name	Grade
Address	Home phone	Date of Birth
City & Zip code	Primary email	Date of last physical exam
Guardian name	Relationship to student	Primary phone #
Home phone #	work phone #	Other contact #
Guardian name	Relationship to student	Primary phone #
Home phone #	work phone #	Other contact #

Medical info

Family physician name	Phone	email
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Medical alerts-please note all that apply

<input type="checkbox"/> Drug allergies <input type="checkbox"/> Eye wear/eye protection <input type="checkbox"/> Concussion, date <input type="checkbox"/> Epi pen carrier <input type="checkbox"/> Food, environmental allergies <input type="checkbox"/> Bee sting allergy <input type="checkbox"/> Current medications <input type="checkbox"/> asthma/inhaler user <input type="checkbox"/> Diabetic <input type="checkbox"/> Most recent injury to be aware of <input type="checkbox"/> Any other condition, ailment to be aware of	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
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Insurance Co.

Policy Number

Expiration date

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Policy holder name

Group number

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Is this an HMO yes_____ no_____

Pay for prescriptions?

Yes_____ no _____

Parent's Medical Consent Statement

In case of emergency, we give consent for our child to have initial treatment by a hospital physician, team physician, or other medical personnel deemed necessary. This permission includes hospital admission or emergency surgery. By my signature and in my absence, I authorize and hereby grant permission in advance of any specific diagnosis, to any X-ray exam, anesthesia, medical, surgical diagnosis or treatment and hospital care that is deemed advisable by, and is rendered under the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or hospital. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California and shall remain in effect, unless sooner revoked in writing and delivered to said agent(s) until the end of the current school year.

Parent/Guardian Signature_____ Date:_____