Perris Union High School District
Athletic Emergency/Medical Information & Participation Form

FALL	WINTER	SPRING	MULTI
☐ Cross Country	☐ Basketball	☐ Baseball	☐ Cheer
☐ Football	☐ Soccer	☐ Boys Golf	☐ Team Manager
☐ Girls Tennis	☐ Wrestling	☐ Softball	☐ Band
☐ Boys Water Polo	☐ Girls Water Polo	☐ Swimming	☐ Color Guard
☐ Girls Volleyball		☐ Boys Tennis	☐ NJROTC
☐ Girls Golf		☐ Track	☐ OTHER:
		☐ Boys Volleyball	

Athlete's Name:		Address:		Today's Date:
City:	State: CA	Zip Code:	Home Phone:	
Grade:	Age:	Gender:	Date of Birth:	Place of Birth:
Father/Guardian's Name:			Phone:	Employer:
Mother/Guardian's Name:			Phone:	Employer:
Emergency Phone Number:		Cell #:	E-Mail:	
Family Physician:		Phone Number:	School attended previous semester:	
List all schools attended in the last 12 months:				

Medical History Questionnaire- This Section must be completed:

	Y	N		Y	N
1. Are you currently under a doctor's care for any reason?	☐	☐	15. Do you have any trouble breathing before or after exercise?	☐	☐
2. Have you ever been hospitalized?	☐	☐	16. Have you had any problems with your eyes or vision?	☐	☐
3. Have you ever had surgery?	☐	☐	17. Do you wear glasses or contacts or protective eye wear?	☐	☐
4. Are you currently taking any medications or pills	☐	☐	18. Do you use any special equipment? (splint, neck rolls, mouth guards, etc.)	☐	☐
5. Do you have any allergies? (medicine, bee sting, etc.)	☐	☐	19. Has anyone in your family died of heart problems or sudden death before the age of 50?	☐	☐
6. Have you ever been dizzy or fainted during or after exercise?	☐	☐	20. Do you only have one working organ of usually paired organs? (eye, kidney, etc.)	☐	☐
7. Have you ever had chest pains during or after exercise?	☐	☐	21. Have you ever sprained, broken, dislocated, or had repeated swelling or pain of any bones or joints?	☐	☐
8. Have you ever had high blood pressure?	☐	☐	22. Are any of the following currently bothering you? Hand / Wrist / Elbow / Forearm / Hip / Thigh / Knee / Ankle / Shin / Calf / Foot	☐	☐
9. Have you ever been told you have a heart murmur?	☐	☐	23. Have you ever had a stinger, burner, or pinched nerve?	☐	☐
10. Have you ever had a racing heart or skipped heartbeats?	☐	☐	24. Have you ever had any medical problems or injuries? (asthma, mono, diabetes, etc.)	☐	☐
11. Have you had a head injury?	☐	☐	25. Have you had any medical problems since your last evaluation?	☐	☐
12. Have you ever been knocked unconscious?	☐	☐	26. Were there any special instructions or precautions given by the Medical Practitioner?	☐	☐
13. Have you ever had a seizure?	☐	☐	27. What was the date of your tetanus shot?		
14. Have you ever been dizzy or passed out due to the heat?	☐	☐	28. (Women Only) Date of your first menstrual period: When was your last menstrual period? Longest period of time between periods last year?		

Explain all "Yes" answers by question numbers, indicate dates for each item and include any special instructions.

I/we hereby state, to the best of my/our knowledge, the answers to the questions for the medical history questionnaire above are true. I/we understand that by performing this examination, the undersigned physician does not assume responsibility for medical care of this individual. **I/we verify that I/we have read and understand all material presented and all information I/we have provided is correct and I/we give permission for my/our child or ward to receive a physical exam and to participate in athletics.** In the event **reasonable attempts** to contact the parent/guardian at the above phone numbers meets with no success, **full authorization** is given for the administration of any treatment deemed necessary by a medical practitioner, and the transfer of son/daughter or ward to any medical practitioner, and the transfer of my/our son/daughter or ward to any licensed hospital or emergency clinic reasonably accessible. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of school authorities and aforesaid agent(s) to give reasonable care. Facts are provided above concerning the student athlete's medical history which a medical practitioner should know.

Family Health Insurance Co.	Policy ID #	
Signature of Athlete		Date:
Signature of Parent or Guardian		Date:

	Blood Pressure	HEENT	Skin	Heart	Lungs	Abdomen	Flexibility/Strength
Normal							
Abnormal							

While this does not constitute a physical nor replace the need for a periodic health evaluation by a family physician, this individual appears to be physically capable of participation in interscholastic sports as of this date except as indicated below.

☐ **Cleared for sport without restrictions**
☐ **Cleared with the following restrictions:**
☐ **Cleared after completing evaluation/rehabilitation for:**
☐ **Not cleared for participation in athletics**

Doctor's Office Stamp:	**Physician's Signature:**	**Date:**

PERRIS UNION HIGH SCHOOL DISTRICT

"Growing Together Through Education"

ATHLETIC PHYSICAL PACKET

SIGNATURE CONSOLIDATION PAGE

We, the undersigned are fully aware of the information contained in the athletic phyiscal packet. By initialing and signing on this page we confirm our consent to follow the rules and policies of the Perris Union High School District.

	Parent	Athlete
Student Record and Media Release Authorization	_____	_____
Athletic Release of Liability	_____	_____
Part 1:	_____	_____
Part 2:	_____	_____
Part 3:	_____	_____
Insurance:	_____	_____
Transportation:	_____	_____
Stadium Turf Agreement:	_____	_____
C.I.F. Sudden Cardiac Arrest:	_____	_____
Concussion Management Protocol	_____	_____
Responsibility to report all injuries	_____	_____
CIF/CDC concussion fact sheet	_____	_____
Concussion is a brain injury	_____	_____
Concussion can affect my ability to perform everyday functions	_____	_____
Symptoms can show up hours or days after the injury	_____	_____
Report suspected teammate concussions	_____	_____
Do not return to play in a game or practice with concussion symptoms	_____	_____
Return to play too soon may increase the chances of a repeat concussion	_____	_____
Repeat concussions can cause permanent brain damage and even death	_____	_____
Impact Consent Form	_____	_____
Impact Consent for Baseline Cognitive Testing	_____	_____
Impact Consent for Post Concussion Cognitive Testing	_____	_____

Name of Parent (Please Print): _____

Parent Signature: _____ Date: _____

Name of Student (Please Print): _____

Student Signature: _____ Date: _____