Athlete's Last Name First Name

ID Number

Perris Union High School District

pency/Medical Information & Participation Form

21.7.7		Aunei	ic Emergency	//1	cuit			1 al uci	pauo				
FALI			WINTER	SPRING MUI				TI					
□ Cross Co	untry	1	Basketball						□ Che				
	□ Football □ Soccer					☐ Boys Golf ☐ Team Mana				_			
□ Girls Ten			Wrestling			□ Softl			□ Baı				
□ Boys Wat	ter Polo		Girls Water Polo	)		□ Swin	nming		□ Col	lor Guard			
□ Girls Vol	leyball					□ Boys	Tennis		□ NJ]	ROTC			
□ Girls Golf						□ Trac	k		□ OT	HER:			
						□ Boys	Volleybal	1					
Athlete's Name	e:			4	Addr	ess:				Tod	lay's Date:		
City:	State	e: CA	Zip Code:				Home Ph	none:					
Grade: Age: Gender:						Date of Bir	th:		Pl	ace of Birth:			
Father/Guardian's Name:						Phone:			Eı	mployer:			
Mother/Guardian's Name:						Phone: Employer:							
Emergency Pho		••	Ce	11 #:			E-Mail:			<u>-</u>			
Family Physicia		•	Phone Nu										
List all schools		the lest		annot	<i>.</i> 1.		benoor at	tteriaca p	ic viou	s semester.			
				at L	0.00-	mploted.							
wieuicai Histor	y Question	шаіге-	This Section mu		e cor N	npietea:						3.7	NT
1 Amo	umda 1 ·	m²a ^		Y		Y N							
1. Are you currently 2. Have you ever be			or any reason?			, e							
3. Have you ever ha		u?				16. Have you had any problems with your eyes or vision? □ 17. Do you wear glasses or contacts or protective eye wear? □							
4. Are you currently		edications	or pills	6							uards etc.)		
,			•				10. Her carrons in your family died of beaut much large on godden deeth before the						
5. Do you have any	allergies? (me	dicine, be	e sting, etc.)			age of 50?	-	-	_				
6. Have you ever be	en dizzy or fai	nted durir	ng 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 yo	ur tetanus s	shot?			I.	l
· ·						28. (Women Only) Date of your first menstrual period:							
14. Have you ever been dizzy or passed out due to the heat?						When was your last menstrual period? Longest period of time between periods last year?							
Explain all "Yes	" answers b	y questi	on numbers, indic	ate d	lates								
Explain all "Yes" answers by question numbers, indicate dates for each item and include any special instructions.													
I/we hereby state, to the be	est of my/our know	vledge, the an	swers to the questions for the	ne medi	cal histo	ory questionnaire abo	ve are true. I/we	understand tha	t by perfor	ming this examination, the	undersigned physic	ian does	not
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 I	Insurance C	<u>'0</u>						Polic	y ID#	:			
Signature of At					1 0110	ушπ	Date			$\dashv$			
Signature of Affilete Signature of Parent or Guardian													
Signature of Pa	ieiii or Gua	ruran								Date	•		
	Blood Pres	ssure	HEENT		Skin	]	Heart	Lun	gs	Abdomen	Flexibility	/Stre	ngth
Normal													
Abnormal While this does not cons	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												c of
While this does not const this date except as indica		or replace th	e need for a periodic heal	ııı evalt	iation b	y a rainiiy physicia	u, uus inaividual	appears to be	pnysically	capable of participation	m mierscholastic	sports a	o Of
	sport without	restriction	ons										
I =	h the followin												
Cleared afte	er completing	evaluatio	n/rehabilitation for	:									
Not cleared	for participat	tion in ath	letics								•		
D 4 1 0 000 000						n•					<b>.</b> .		
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 physical 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:		
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 Cognitive Testing and Release of Information Form.		
Name of Parent (Please Print):		
Parent Signature:	Data	:
i dient dignature.		•
Name of Student (Please Print):		
Student Signature:	Date	<b>:</b>