



# Sweetwater Union High School District

1130 Fifth Avenue, Chula Vista CA 91911 619-585-6015

## Sports/Co-curricular Participation Screening Risk Assessment

STUDENT NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_  
SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_  
SPORT(S): \_\_\_\_\_ GENDER: Male Female Non-Binary  
ADDRESS: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
FATHER'S WORK PHONE: \_\_\_\_\_ FATHER'S CELL PHONE: \_\_\_\_\_  
MOTHERS WORK PHONE: \_\_\_\_\_ MOTHER'S CELL PHONE: \_\_\_\_\_  
FAMILY DOCTOR: \_\_\_\_\_ DOCTOR'S PHONE: \_\_\_\_\_  
EMERGENCY CONTACT NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
EMERGENCY CONTACT HOME/CELL PHONE: \_\_\_\_\_

### **MEDICAL HISTORY - Please answer the following questions regarding your student. Please explain "YES" answers below.**

1	Has or had injuries requiring medical attention?	Yes	No
2	Has or had an illness requiring hospitalization?	Yes	No
3	Has or had coughing, wheezing, or trouble breathing during or after activity?	Yes	No
4	Has or had asthma?	Yes	No
5	Have had seasonal allergies that require medical treatment?	Yes	No
6	Are you currently taking any prescription or non-prescription (over the counter) medications or pills or using an inhaler?	Yes	No
7	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	Yes	No
8	Have you ever passed out during or after exercise that require medical treatment?	Yes	No
9	Have you ever been dizzy during or after exercise that require medical treatment?	Yes	No
10	Have you ever had chest pain during or after exercise that require medical treatment?	Yes	No
11	Have you ever had racing of your heart or skipped heartbeats that require medical treatment?	Yes	No
12	Have you ever been told you have a heart murmur?	Yes	No
13	Have you ever been told you have high blood pressure? <b>* NO CAFFINATED DRINKS 4 HOURS PRIOR TO SCREENING*</b>	Yes	No
14	Has any family member or relative died of heart problems or of sudden death before age 55?	Yes	No
15	Has a physician ever denied or restricted your participation in sports for any heart problems?	Yes	No
16	Have you ever had a head injury or concussion, been knocked out, become unconscious, or lost your memory?	Yes	No
17	Have you ever had a seizure?	Yes	No
18	Do you have frequent or severe headaches that require medical treatment?	Yes	No
19	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	Yes	No
20	Have you ever had a stinger, burner, or pinched nerve?	Yes	No
21	Is hearing impaired, and/or has glasses/contact lenses? <b>**MUST BRING CONTACTS/GLASSES TO SCREENING**</b>	Yes	No

Please explain any "YES" responses: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have reviewed this medical history. In case of injury I hereby give consent for my son/daughter to have initial first aid administered by school personnel in charge and to be transported to a doctor or hospital for further treatment if necessary.

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**



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## Parent Consent

STUDENT NAME: \_\_\_\_\_ SCHOOL: \_\_\_\_\_

SPORT(S): \_\_\_\_\_ GENDER: Male Female Non-Binary

I hereby give my consent for my student \_\_\_\_\_ to be given a Sport/ Co-curricular Participation Screening Examination and (if indicated an EKG/ECHO CARDIOGRAM/ Baseline Concussion Testing) by a team of Sports Medicine Specialists (Orthopedic Surgeon, Family Practitioner, Certified Athletic Trainer and Physical Therapist).

Parent/Guardian Signature \_\_\_\_\_

DATE \_\_\_\_\_

## PHYSICAL EXAM

Height:	_____	Weight:	_____
Blood Pressure*:	_____	Pulse:	_____
Vision (R):	_____	Vision (L):	_____
Flexibility/Posture:	<u>Normal</u>	<u>Abnormal</u>	
ROM Screens:		Blood Pressure RE-CHECK*:	
Upper Extremities	_____	_____	2 <sup>nd</sup> _____
Lower Extremities	_____	_____	3 <sup>rd</sup> _____
Scoliosis	NO	YES	
Comments:	_____		

## ORTHOPEDIC EXAMINATION

<u>Upper Extremities</u>			<u>Lower Extremities</u>		
	<u>Normal</u>	<u>Abnormal</u>		<u>Normal</u>	<u>Abnormal</u>
Shoulder	_____	_____	Hip	_____	_____
Elbow	_____	_____	Knee	_____	_____
Wrist/Hand	_____	_____	Ankle	_____	_____
Spine	_____	_____	Foot	_____	_____
Comments:	_____				

## ORTHOPEDIC DETERMINATION - In my opinion this student (please check one):

☐ Is CLEARED for sports/co-curricular participation ☐ Is NOT-CLEARED for sports/co-curricular participation ☐ Ortho Deferred

Ortho Physician: \_\_\_\_\_ MD /DO Date of Physical: \_\_\_\_\_

## PHYSICAL EXAMINATION

	<u>Normal</u>	<u>Abnormal</u>		<u>Normal</u>	<u>Abnormal</u>	
Head & Neck	_____	_____	Cardiovascular	_____	_____	Female - Age of 1 <sup>st</sup> menstrual cycle: _____
Eyes	_____	_____	Gastrointestinal	_____	_____	
Ears/Nose & Throat	_____	_____	Genito-Urinary	_____	_____	

Comments: \_\_\_\_\_

## PHYSICIAN DETERMINATION In my opinion this student (please check one):

☐ Is CLEARED for sports/co-curricular participation ☐ Is NOT-CLEARED for sports/co-curricular participation ☐ Medical Deferred

Physician: \_\_\_\_\_ MD /DO Date of Physical: \_\_\_\_\_

EKG/ECHO REFERRAL: ☐ Is CLEARED if EKG is within NORMAL limits.

☐ EKG completed & within NORMAL limits? YES NO ☐ Cardiac Deferred

EKG/ ECHO Comments: \_\_\_\_\_

Comments on Medical History: \_\_\_\_\_

NOTE: Hospital, Clinic or Doctor's Stamp  
REQUIRED