C.I.F. ATHLETIC PARTICIPATION HEALTH FORM
SANTA BARBARA UNIFIED SCHOOL DISTRICT
HEALTH SERVICES
STUDENT INFORMATION to be completed by student-Parent signature REQUIRED

Name: _____
LAST FIRST
Address: _____

HISTORY:

1. Have you had (circle if Yes) allergies, asthma, seizures, heart murmur, a broken bone, diabetes, surgery or hospitalization
Explain: _____
2. Do you wear corrective lenses during sports? YES_____ NO_____
3. Is your hearing normal? YES_____ NO_____
4. Do you take any medications? YES_____ NO_____ If YES, what? _____
5. Please note any other medical information that school personnel may need to know: _____

Parent/Guardian Permission for EXAM: _____ DATE:_____

ORIGINAL MUST BE RETURNED TO SCHOOL-NO COPIES
PHYSICIAN INFORMATION – TO BE COMPLETED BY PHYSICIAN OR NURSE PRACTITIONER ONLY
PHYSICAL EXAMINATION

Height: _____ Weight: _____ BP:_____/_____ Pulse:_____ Code: 0 = Negative X = Positive NE: =No Examination

1) Ears, Nose, Throat		8) Musculoskeletal Evaluation	
2) Eyes - pupil equal reactive		8.1) Flexibility/stability of joints	
Symmetry of eye movement		Gait Hand	
3) Dental - Missing teeth		Knee Bend	
Chipped teeth		8.2) Spine - scoliosis	
Removable teeth		8.3) Swelling of joints	
Orthodontia		8.4) Muscular weakness	
4) Lungs		8.5) Atrophy	
5) Heart		Thigh Shoulder Girdle	
6) Abdomen		Calf Arm	
7) Hernia		9) Incoordination/loss of balance	

Additional findings, comments and/or recommendations: _____
_____

"I certify that I have on this date examined this student and that on the basis of the exam requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities"

IF STUDENT IS NOT MEDICALLY FIT TO PARTICIPATE IN ATHLETICS OR IF THERE ARE EXCEPTIONS TO THE A BOVE STATEMENT, EXAMINING PHYSICIAN SHOULD INDICATE ABOVE.

Signature of Examining Physician: _____ Phone: _____

Print Name: _____ Date: _____Agency: _____