Glendale Union High School District
Pre-participation Physical Evaluation

School ____________________ I.D.# ____________________

Name ________________________________ Sex ________ Age ______ Date of Birth ____________

Address ____________________________ City ____________ State ________ Zip Code ____________

Parent(s) / Guardian Name ____________________________ Family Physician ____________________

Phone (H) ______________ Phone (W) ______________ Physician Phone ____________________

Phone (C) ______________ Preferred Hospital ____________________

In Case of Emergency, Contact Name ________________________ Relationship ____________________

Phone (H) ______________ (W) ______________ (C) ______________

Athletic Physicals for the following year MUST be completed on or after March 1 per AIA rules

Question	Yes	No
1.Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
Do you have an ongoing or chronic condition?	☐	☐
Are you currently being treated by a physician?	☐	☐
________________________________		
2. Have you ever been hospitalized overnight?	☐	☐
Have you ever had surgery?	☐	☐
3. Are you currently taking any prescription or nonprescription medications or using an inhaler?	☐	☐
________________________________		
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
4. Do you have any allergies to medications?	☐	☐
Do you have any allergies to pollen, food, or stinging insects?	☐	☐
________________________________		
Have you ever had a rash or hives after exercise?	☐	☐
5. Have you ever passed out during or after exercise?	☐	☐
Have you ever been dizzy during or after exercise?	☐	☐
Have you ever had chest pain during or after exercise?	☐	☐
Do you get tired more quickly than your friends during exercise?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Have you had high blood pressure or high cholesterol?	☐	☐
Have you been told you have a heart murmur?	☐	☐
Have you had a severe viral infection (i.e. mononucleosis or myocarditis) within the last month?	☐	☐
Has a doctor ever denied or restricted your participation in sports for any heart problems?	☐	☐
Has anyone in your immediate family had the following conditions?	☐	☐
Diabetes________Heart disease________ other________		
Sudden death prior to age 50___High blood pressure_____		
6. Are your teeth healthy and sound?	☐	☐
7. Do you have any current skin problems (i.e. itching, rashes, acne, warts, fungus, or blisters)?	☐	☐

Question	Yes	No
8. Have you ever had a head injury or concussion?	☐	☐
Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
Have you ever had a seizure?	☐	☐
Do you have frequent or severe headaches?	☐	☐
Have you ever had a stinger, burner, or pinched nerve?	☐	☐
9. Have you ever become ill from exercising in the heat?	☐	☐
10. Do you cough, wheeze, or have trouble breathing during or after activity?	☐	☐
Do you have asthma?	☐	☐
Do you use an inhaler? Type:	☐	☐
Do you have allergies that require medical treatment?	☐	☐
11. Have you had any problems with your vision?	☐	☐
Do you wear glasses, contacts, or protective eyewear?	☐	☐
12. Have you ever had a sprain or strain?	☐	☐
Have you broken or fractured any bones or dislocated any joints?	☐	☐

If yes, check appropriate below

Head	Elbow	Hip
Neck	Forearm	Thigh
Back	Wrist	Knee
Chest	Hand	Shin / calf
Shoulder	Finger	Ankle
Upper arm		Foot

Question	Yes	No
13. Do you feel stressed?	☐	☐

14. Do you or have you ever used:
Smokeless tobacco__________ Cigarettes_________
Alcohol______________ Recreational drugs__________

Question	Yes	No
15. Do you want to weigh more or less than you do now?	☐	☐
Do you lose weight regularly to meet weight requirements for your sport?	☐	☐

Females Only

16. When was your first menstrual period?______________
When was your most recent menstrual period?______________
How many periods have you had in the last year?____________
What was the longest time between periods in the last year? ______________________

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.
I understand and acknowledge that truthful and accurate information is essential in properly determining whether the student should be cleared for athletic participation.
I hereby consent for the student named above, to be given medical care by the doctor selected by the school.

______________________ ______________________ ______________

Signature of Parent / Guardian | Signature of Student Athlete | Date

Sports YOU MAY ONLY CHECK ONE PER SEASON

FALL SEASON

- ❑ Badminton
- ❑ B Cross Country
- ❑ G Cross Country
- ❑ Football
- ❑ B Golf
- ❑ G Golf
- ❑ Spiritline
- ❑ B Swim / Dive
- ❑ G Swim / Dive
- ❑ Volleyball

WINTER SEASON

- ❑ B Basketball
- ❑ G Basketball
- ❑ B Soccer
- ❑ G Soccer
- ❑ Wrestling

Have you attended any other High School?

_________ YES
_________ NO

SPRING SEASON

- ❑ Baseball
- ❑ Softball
- ❑ B Tennis
- ❑ G Tennis
- ❑ B Track
- ❑ G Track

If Yes, Did you participate in sports?

_________ YES
_________ NO

TO BE COMPLETED BY PHYSICIAN

Student Name ______________________________ Date ____________________

Height ____________________ Pulse _________ B/P ____________
Weight ____________________ Pupils: Equal __________ Unequal ____________
Vision: Wears:
R 20 / __________ Glasses ________
L20 / __________ Contacts ________

	NORMAL	ABNORMAL FINDINGS
MEDICAL		
Appearance		
Ears /Nose / Throat		
Hearing		
Heart		
Lungs		
Abdomen		
Genitourinary		

	NORMAL	ABNORMAL FINDINGS
MUSCULOSKELETAL		
Neck		
Back		
Shoulder / arm		
Elbow / forearm		
Wrist / hand / fingers		
Hip / thigh		
Knee		
Leg / ankle		
Foot / toes		

Cleared _________ **Not Cleared for:** ________________ **Reason:** ____________________
Cleared after completing evaluation / rehabilitation for: ______________________________

Recommendations: ____

Name of physician (print) ______________________________________

Address ______________________________________ **Phone** ________________

Office Stamp:

Signature of physician ______________________________ **Date** ________________