⭐ NEW! Chico High Athletics has an online process for athletic clearances! ⭐

1. Go to **athleticclearance.com**
2. Click on CA and first register as a new account user
3. Information needed as you begin the process:
    a. Insurance information-company & policy number
    b. Medication list
    c. Prior injury information
    d. Student ID #, Student email, student cell
    e. Both athlete and parent should be there for signatures
4. Once logged in, click on-*Start Clearance Here*- and begin the process.
5. Once process is completed, the last page says to print and sign. It is not necessary to do this step.
6. Physical forms are still required and are available in the CHS Main Office, Athletics office or school website: **chs.chicousd.org/athletics**.

Completed physical forms must be turned in to the Athletics office before any athlete is eligible to practice.

⭐ **Chico High Physical Night is May 22nd at 6pm**. ⭐
Start in the front of the school. $10 donation requested. Plan to be here 1-2 hours.

Any questions, please email Kelley Serl at kserl@chicousd.org or call 530-891-3026 ext 102.

Revised 7/1/05 - Mandatory

Preparticipation Physical Evaluation

HISTORY FORM

Name _____ Sex _____ Age _____ Date of birth _____

Grade ____ School _____ Sport(s) _____

Address _____ Phone _____

Personal Physician _____

Insurance Company:_____ **Policy Number:**_____ **REQUIRED**

*Please check with your insurance agent to be sure your plan includes tackle football if your child intends to participate in that sport.

In case of emergency, contact: Name_____ Relationship_____ Phone: _____

Explain "Yes" answers below. Circle questions you do not know the answers to.

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or non-prescription (over-the-counter) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection		
10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below:	☐	☐
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐
Head, Neck, Shoulder, Upper Arm, Elbow, Forearm, Hand/ Fingers, Chest, Upper Back, Lower Back, Hip, Thigh, Knee, Calf/Shin, Ankle, Foot/ Toes		
20. Have you ever had a stress fracture?	☐	☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐
23. Has a doctor ever told you that you have asthma or allergies?	☐	☐

	Yes	No
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25. Is there anyone in your family who has asthma?	☐	☐
26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30. Have you had a herpes skin infection?	☐	☐
31. Have you ever had a head injury or concussion?	☐	☐
32. Have you been hit in the head and been confused or lost your memory?	☐	☐
33. Have you ever had a seizure?	☐	☐
34. Do you have headaches with exercise?	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39. Have you had any problems with your eyes or vision?	☐	☐
40. Do you wear glasses or contact lenses?	☐	☐
41. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42. Are you happy with your weight?	☐	☐
43. Are you trying to gain or lose weight?	☐	☐
44. Has anyone recommended you change your weight or eating habits?	☐	☐
45. Do you limit or carefully control what you eat?	☐	☐
46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
FEMALES ONLY		
47. Have you ever had a menstrual period?	☐	☐
48. How old were you when you had your first menstrual period?____		
49. How many periods have you had in the last 12 months?_____		

Explain "Yes" answers here:

_____

Signature of Athlete_____ **Signature of PARENT:** _____ Date: _____

Pre-participation Physical Evaluation

PHYSICAL EXAMINATION FORM

Name_____ Date of Birth_____

Height_____ Weight_____ %Body Fat (optional)_____ Pulse_____ BP____/____(____/____, ____/____)

Vision R 20/_____ L20/_____ Corrected: Y N Pupils: Equal_____ Unequal_____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

STUDENT NAME: ID# DATE GR

*Multiple-examiner set-up only.
+Having a third party present is recommended for the genitourinary examination.

Notes:_____
_____

Name of physician (print/type)_____ Date_____

Address_____ Phone_____

Signature of physician_____, MD or DO