CHS Physical Night

Wednesday, May 22\textsuperscript{nd}

6pm-8pm

Check-in front of the school

$10 Donation requested

Please complete parent/student portion of the physical form and bring with you.

Visit [athleticclearance.com](https://athleticclearance.com) to complete the online clearance process.
*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.
Preparticipation Physical Evaluation

HISTORY FORM

Name ___________________________ Sex _______ Age _______ Date of birth _______

Grade _______ School _____________ Sport(s) _____________

Address ___________________________ Phone ___________________________

Personal Physician ___________________________ Phone: ___________________________

A. Insurance Company: ________________________________________________________
   Policy Number: _____________________________________________________________

   *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.

1. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram) ______ No ______ Yes
2. Has anyone in your family died for no apparent reason? ______ No ______ Yes
3. Does anyone in your family have a heart problem? ______ No ______ Yes
4. Has anyone in your family died of heart problems or of sudden death before age 50? ______ No ______ Yes
5. Does anyone in your family have Marfan syndrome? ______ No ______ Yes
6. Have you ever spent the night in a hospital? ______ No ______ Yes
7. Have you ever had surgery? ______ No ______ Yes

   Head: _______ Neck: _______ Shoulder: _______ Upper Arm: _______ Elbow: _______
   Forearm: _______ Hand/Fingers: _______ Chest: _______

   Calf/Shin: _______ Ankle: _______ Foot/Toes: _______

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: ______ No ______ Yes
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: ______ No ______ Yes
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: ______ No ______ Yes

20. Have you ever had a stress fracture? ______ No ______ Yes
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? ______ No ______ Yes
22. Do you regularly use a brace or assistive device? ______ No ______ Yes
23. Has a doctor ever told you that you have asthma or allergies? ______ No ______ Yes

24. Do you cough, wheeze, or have difficulty breathing during or after exercise? ______ No ______ Yes
25. Is there anyone in your family who has asthma? ______ No ______ Yes
26. Have you ever used an inhaler or taken asthma medicine? ______ No ______ Yes
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? ______ No ______ Yes
28. Have you had infectious mononucleosis (mono) within the last month? ______ No ______ Yes
29. Do you have any rashes, pressure sores, or other skin problems? ______ No ______ Yes
30. Have you had a herpes skin infection? ______ No ______ Yes
31. Have you ever had a head injury or concussion? ______ No ______ Yes
32. Have you been hit in the head and been confused or lost your memory? ______ No ______ Yes
33. Have you ever had a seizure? ______ No ______ Yes
34. Do you have headaches with exercise? ______ No ______ Yes
35. Have you ever been unable to move your arms or legs after being hit or falling? ______ No ______ Yes
36. Have you ever had a bone or joint injury that required physical therapy, a brace, a cast, or crutches? If yes, circle affected area below: ______ No ______ Yes
37. Do you regularly use a brace or assistive device? ______ No ______ Yes
38. Have you ever had a heart infection? ______ No ______ Yes
39. Has a doctor ever told you that you have asthma or allergies? ______ No ______ Yes
40. Do you wear glasses or contact lenses? ______ No ______ Yes
41. Do you wear protective eyewear, such as goggles or a face shield? ______ No ______ Yes
42. Are you happy with your weight? ______ No ______ Yes
43. Are you trying to gain or lose weight? ______ No ______ Yes
44. Has anyone recommended you change your weight or eating habits? ______ No ______ Yes
45. Do you limit or carefully control what you eat? ______ No ______ Yes
46. Do you have any concerns that you would like to discuss with a doctor? ______ No ______ Yes

FEMALES ONLY

47. Have you ever had a menstrual period? ______ No ______ Yes
48. How old were you when you had your first menstrual period? ______ No ______ Yes
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

**Name__________________________ Date of Birth_______________________**

Height_________ Weight__________ %Body Fat (optional)________

Pulse_________ BP____/____ (____/____, ____/____)

Vision R 20/________ L20/________

Corrected: Y N

Pupils: Equal______ Unequal______

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<th><strong>NORMAL</strong></th>
<th><strong>ABNORMAL FINDINGS</strong></th>
<th><strong>INITIALS</strong>*</th>
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<td>Genitourinary (males only)+</td>
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<td>Skin</td>
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**MUSCULOSKELETAL**

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<th>Shoulder/arm</th>
<th>Elbow/forearm</th>
<th>Wrist/hand/fingers</th>
<th>Hip/thigh</th>
<th>Knee</th>
<th>Leg/ankle</th>
<th>Foot/toes</th>
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*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