



CHS Physical Night



Wednesday, May 22nd

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 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.

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 | | Yes | No |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | <input type="checkbox"/> | <input type="checkbox"/> | 24. Do you cough, wheeze, or have difficulty breathing during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an ongoing medical condition (like diabetes or asthma)? | <input type="checkbox"/> | <input type="checkbox"/> | 25. Is there anyone in your family who has asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or non-prescription (over-the-counter) medicines or pills? | <input type="checkbox"/> | <input type="checkbox"/> | 26. Have you ever used an inhaler or taken asthma medicine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects? | <input type="checkbox"/> | <input type="checkbox"/> | 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out or nearly passed out DURING exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 28. Have you had infectious mononucleosis (mono) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever passed out or nearly passed out AFTER exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 29. Do you have any rashes, pressure sores, or other skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had discomfort, pain, or pressure in your chest during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 30. Have you had a herpes skin infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does your heart race or skip beats during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 31. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has a doctor ever told you that you have (check all that apply): | | | 32. Have you been hit in the head and been confused or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur | | | 33. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection | | | 34. Do you have headaches with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram) | <input type="checkbox"/> | <input type="checkbox"/> | 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has anyone in your family died for no apparent reason? | <input type="checkbox"/> | <input type="checkbox"/> | 36. Have you ever been unable to move your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does anyone in your family have a heart problem? | <input type="checkbox"/> | <input type="checkbox"/> | 37. When exercising in the heat, do you have severe muscle cramps or become ill? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has any family member or relative died of heart problems or of sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Does anyone in your family have Marfan syndrome? | <input type="checkbox"/> | <input type="checkbox"/> | 39. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever spent the night in a hospital? | <input type="checkbox"/> | <input type="checkbox"/> | 40. Do you wear glasses or contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 41. Do you wear protective eyewear, such as goggles or a face shield? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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: | <input type="checkbox"/> | <input type="checkbox"/> | 42. Are you happy with your weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: | <input type="checkbox"/> | <input type="checkbox"/> | 43. Are you trying to gain or lose weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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: | <input type="checkbox"/> | <input type="checkbox"/> | 44. Has anyone recommended you change your weight or eating habits? | <input type="checkbox"/> | <input type="checkbox"/> |
| Head Neck Shoulder Upper Arm Elbow Forearm Hand/Fingers Chest | | | 45. Do you limit or carefully control what you eat? | <input type="checkbox"/> | <input type="checkbox"/> |
| Upper Back Lower Back Hip Thigh Knee Calf/Shin Ankle Foot/Toes | | | 46. Do you have any concerns that you would like to discuss with a doctor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you ever had a stress fracture? | <input type="checkbox"/> | <input type="checkbox"/> | FEMALES ONLY | | |
| 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | <input type="checkbox"/> | <input type="checkbox"/> | 47. Have you ever had a menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you regularly use a brace or assistive device? | <input type="checkbox"/> | <input type="checkbox"/> | 48. How old were you when you had your first menstrual period? _____ | | |
| 23. Has a doctor ever told you that you have asthma or allergies? | <input type="checkbox"/> | <input type="checkbox"/> | 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