MBUSD – Mira Costa High School
Pre-participation Physical Evaluation

Female___ Male___
Year 2019/2020

Print Last Name | First Name | Middle Initial | Date of Birth | Grade | Sport

Address | City | Zip | Home Phone Number

Did you transfer from another high school? ☐ Yes ☐ No If yes, list date, name, city and state of last high school attended.

Father/Guardian's Name | Father/Guardian's Phone Number | Mother/Guardian's Name | Mother/Guardian's Phone No.

Father's Work Number | Mother's Work Number | Others to Call in Emergency (Name and Phone Number)

HEALTH HISTORY (To be completed by student & parent): Check "yes" or "no" and give as much information as possible.

☐ Yes ☐ No Heart Trouble ☐ Yes ☐ No Asthma ☐ Yes ☐ No Diabetes ☐ Yes ☐ No Seizures
☐ Yes ☐ No Palpitations ☐ Yes ☐ No Fatigue ☐ Yes ☐ No High Blood Pressure ☐ Yes ☐ No Chest Pain
☐ Yes ☐ No Current Skin Condition ☐ Yes ☐ No Dizziness/Fainting ☐ Yes ☐ No Extreme Shortness of Breath/Wheezing
☐ Yes ☐ No Kidney Problems ☐ Yes ☐ No History of family member with heart attack under 50yrs of age or sudden death.
☐ Yes ☐ No Other: Glasses/Contacts, Protective Equipment, or Hearing Aid ☐ Yes ☐ No Head Trauma/Loss of Consciousness

Other:

History of any previous injuries, fractures, serious illnesses or operations/hospitalizations (describe and give approximate dates)

Current medications | Allergies | Date of Last Tetanus Shot

PARENT CONSENT

I hereby state that the above information is true and correct and give my consent for the above-named student to compete in sports and go with a representative of the school on any trips. In case of injury, the school representative is authorized to have him/her treated.

▶ _____ ▶ _____ ▶ _____ ▶ _____

Date | **Parent/Guardian Signature** | **Name of Insurance Co.** | **Policy/Group No.**

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PHYSICAL EXAMINATION (To be completed by physician):

Visual Acuity (Distance): O.D. _____/_____ O.S. _____/_____ ( ) Corrected ( ) Uncorrected

Height_____ Weight_____ Blood Pressure_____ Pulse_____

	Normal		Normal
1. Eyes, Ears, Nose, Throat		9. Musculoskeletal	
2. Neck		Neck	
3. Cardiovascular		Spine	
EKG results (if done)		Shoulders	
4. Chest and Lungs		Arms/Hands	
5. Abdomen		Hips	
6. Skin		Thighs	
7. Genitalia-Hernia (male)		Knees	
8. Neuromuscular		Ankles	
		Feet	

Comments:

RECOMMENDATION:
( ) Full Activity – No restrictions
( ) No contact sports
( ) Other_____
( ) Activity with restrictions:_____
( ) No Participation

EXAMINING PHYSICIAN: DATE OF EXAM: ▶ _____

Print name: ▶ _____ Signature: ▶ _____

LICENSE #:▶ _____ Print or Stamp Address: ▶ _____ Phone: ▶ _____