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Santa Cruz City Schools
Pre-Physical Information Sheet

To be completed by Parent/Guardian

Student Name:_____

Age:_____ Grade: School: Activity:_____

Please click the box next to any question that would be answered with a Yes:

- ☐ 1. Are you under a doctor's care for any reason?
- ☐ 2. Have you ever been hospitalized?
- ☐ 3. Have you ever had surgery?
- ☐ 4. Are you currently taking any medication, inhalers or pills?
- ☐ 5. Do you have any allergies? (bee stings, medicines, etc)
- ☐ 6. Have you ever been dizzy or passed out during or after exercise?
- ☐ 7. Have you ever had chest pains during or after exercise?
- ☐ 8. Have you ever had high blood pressure?
- ☐ 9. Have you ever been told you have a heart murmur?
- ☐ 10. Have you ever had racing of your heart or skipped heartbeats?
- ☐ 11. Have you ever had a head injury?
- ☐ 12. Have you ever been knocked out or unconscious?
- ☐ 13. Have you ever had a seizure?
- ☐ 14. Have you ever had a stinger, burner or pinched nerve?
- ☐ 15. Have you ever been dizzy or passed out in the heat?
- ☐ 16. Do you have trouble breathing or coughing during or after exercise?
- ☐ 17. Do you have any skin problems such as rashes, itching, etc?
- ☐ 18. Do you have any problems with your eyes or with your vision?
- ☐ 19. Do you wear contacts, glasses or protective eye wear?
- ☐ 20. Do you use any special equipment such as splints, neck rolls, mouth guards, etc?
- ☐ 21. Has anyone in your family died of heart problems or sudden death before age 50?
- ☐ 22. Do you have only one working organ of usually paired organs (kidneys, eyes, etc)?
- ☐ 23. Have you ever sprained, broken, dislocated, or had repeated swelling of any bones or joints?

If you answered yes to the above question, please mark which of the following is applicable:

☐ Head ☐ Neck ☐ Chest ☐ Shoulder ☐ Back

☐ Hand ☐ Wrist ☐ Elbow ☐ Forearm

☐ Hip ☐ Thigh ☐ Knee ☐ Ankle ☐ Shin ☐ Calf ☐ Foot

Please click the box next to any question that would be answered with a Yes:

- ☐ 1. Do any of the injuries circled in the last question currently bother you?
- ☐ 2. Do you have any other medical problems such as asthma, mono, diabetes, etc?
- ☐ 3. Have you had any medical injuries or problems since your last medical evaluation?
- ☐ 4. Any special instructions or precautions the school and coaches should be aware of?
- ☐ 5. What was the date of your last tetanus shot?
- ☐ 6. Do you use any tobacco products?
- ☐ 7. **WOMEN ONLY** - Are you having irregular periods?

IF YOU CHECKED THE BOX NEXT TO ANY OF THE QUESTIONS LISTED ABOVE, PLEASE PROVIDE A COMPLETE EXPLANATION BELOW

I/We hereby state that to the best of my/our knowledge, the answers are correct. I/we understand that by performing this examination, the undersigned physician does not assume responsibility for the medical care of this individual.

Athlete Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____