Rocklin High School

Physical Evaluation – Page 1 (to be completed by parent/guardian)

Student Name: ____________________

Date of Birth: ____________________

Gender: Male _____ Female _____ (Check one)

Sport(s): ____________________

Grade Level: (Circle one) 9 10 11 12

Physician Name: ____________________

Physician Address: ____________________ Physician Phone: ____________________

Medical Insurance: ____________________

Policy Number: ____________________

Complete the information below.

Yes _____ No _____ Have you ever been hospitalized?
Yes _____ No _____ Have you ever had surgery?
Yes _____ No _____ Are you presently taking any medications?
Yes _____ No _____ Have you ever passed out during or after exercise?
Yes _____ No _____ Have you ever been dizzy during or after exercise?
Yes _____ No _____ Have you ever had chest pain during or after exercise?
Yes _____ No _____ Have you ever had high blood pressure?
Yes _____ No _____ Have you ever had racing of your heart or skipped heartbeats?
Yes _____ No _____ Has anyone in your family died of heart problems or a sudden death before age 50?
Yes _____ No _____ Do you have any skin problems (itching, rashes, etc.)?
Yes _____ No _____ Have you ever had a head injury?
Yes _____ No _____ Have you ever been knocked out of unconscious?
Yes _____ No _____ Have you ever had a seizure?
Yes _____ No _____ Have you ever had a stinger, burner, or pinched nerve?
Yes _____ No _____ Have you ever had heat or muscle cramps?
Yes _____ No _____ Have you ever been dizzy or passed out in the heat?
Yes _____ No _____ Do you have trouble breathing or do you cough during or after activity?
Yes _____ No _____ Do you use any special equipment (pads, braces, mouth guard, eye guard, etc.)?
Yes _____ No _____ Have you had any problems with your eyes or vision?
Yes _____ No _____ Do you wear glasses, contacts, or protective eyewear?
Yes _____ No _____ Have you ever sprained, strained, dislocated, fractured, or had repeated swelling of any bones/joints?
Yes _____ No _____ Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?
Yes _____ No _____ Have you had a medical problem or injury since your last evaluation?
Yes _____ No _____ Are you missing any paired organs?

1. Explain any "yes" answers from above. ____________________
____
____
2. When was your last tetanus shot? ____________________
3. When was your last measles immunization? ____________________
4. Are there other medical concerns the athletic department needs to be aware of? ____________________
____

By signing below I hereby state that to the best of my knowledge, the answers above are correct.

Signature of athlete:____________________ Date: ____________________

Signature of parent/guardian: ____________________ Date: ____________________

Rocklin High School

Physical Evaluation – Page 2 (to be completed by Physician)

Student Name: ______________________________

Date of Birth: ______________________________

Height: ______________________________

Weight: ______________________________

Blood Pressure: ______________________________

Pulse: ______________________________

Vision: Right 20/_____ Left 20/_____

Corrected: ______________________________

Pupils: ______________________________

Allergies: ______________________________

Category	Normal	Abnormal	Initials
Cardiopulmonary			
Pulses			
Heart			
Lungs			
Tanner Stage (1-5)			
Skin			
Abdominal			
Genitalia			
Musculoskeletal			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			
Other			

Clearance (check the appropriate box below):

- ☐ Cleared
- ☐ Cleared after completing evaluation/rehabilitation for: ______________________________
- ☐ Not cleared for (please circle appropriate box)
  - Collision
  - Contact
  - Non-contact

Recommendation: ______________________________

____

____

Physician Name & Phone: ______________________________

Physician Address: ______________________________

Signature of Physician: ______________________________ Date: ______________