LIVERMORE VALLEY JOINT UNIFIED SCHOOL DISTRICT
685 East Jack London Boulevard
Livermore, CA 94551
www.livermoreschools.com

Pre-participation Physical Evaluation

Athlete History (page 1 of 2)

PART I. Student Information

Name: _____ Date of Birth: _____
Last First Middle

Address: _____ City: _____ Zip: _____

Home Phone: _____ Other Phone: _____

Primary Doctor: _____ Medical Insurance Company: _____

School: _____ Grade: _____ Sport(s): _____

Parent/Guardian: _____ Relationship: _____

PART II. Medical History (Explain "Yes" answers below. Circle questions you don't know the answers to.)

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or nonprescription medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has you doctor over told you that you have (check all that apply)		
☐ High Blood Pressure ☐ High Cholesterol		
☐ A heart murmur ☐ A heart infection		
10. Has a doctor ever ordered a test for your heart (EKG or electrocardiogram)?	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐

If the answer to question 17,18, or 19 is yes, circle area below:

17. Have you ever had an injury that caused you to miss a practice or game?
18. Have you ever had any broken or fractured bones or dislocated joints?
19. Have you ever had a bone or joint injury that required MRI, CT, surgery, injections, rehabilitation, a brace, cast or crutches?

Head	Neck	Shoulder	Upper Arm
Elbow	Forearm	Hand/Fingers	Chest
Back	Hip	Thigh	Knee
Calf/Shin	Ankle	Foot/Toes	

	Yes	No
20. Have you ever had a stress fracture?	☐	☐
21. Have you ever been told that you have atlantoxial (neck) instability?	☐	☐
22. Do you regularly use any braces?	☐	☐
23. Has a doctor ever told you that you have asthma or allergies?	☐	☐
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25. Have you ever used an inhaler or taken asthma medicine?	☐	☐
26. Were you born without, or are you missing a kidney, an eye, a testicle, or any other organs?	☐	☐
27. Have you had infectious mononucleosis within the last month?	☐	☐
28. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
29. Have you ever had a herpes skin infection?	☐	☐
30. Have you ever had a head injury or concussion?	☐	☐
31. Have you ever been hit in the head and been or lost your memory?	☐	☐
32. Have you ever had a seizure?	☐	☐
33. Do you have headaches with exercise?	☐	☐
34. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
35. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
36. When exercising, in the heat, do you have severe muscle cramps or become ill?	☐	☐
37. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
38. Have you ever had any problems with your vision or eyes?	☐	☐
39. Do you wear glasses or contact lenses?	☐	☐
40. Are you happy with your weight?	☐	☐
41. Are you trying to gain or lose weight?	☐	☐
42. Has anyone recommended you change your weight or eating habits?	☐	☐
43. Do you limit or carefully control what to eat?	☐	☐
44. Have you ever taken any supplements to help you gain or lose weight or improve your performance?	☐	☐
FEMALES ONLY:		
45. Have you ever had a menstrual period?	☐	☐
46. How many periods have you had in the last 12 months? _____		

I hereby state that to the best of my knowledge, the answers and information listed above (including insurance) are to be complete and accurate. It is also my understanding that I am granting permission for the Livermore Valley Joint Unified School District, Alameda County and Contra Costa County, California, to transport the above-named student to and from school sponsored activities including, but not limited to study trips, athletic, and social events. I hereby give my consent for the above-named (son or daughter) to compete in sports or extra-curricular activities. In the event this student is injured or there is an emergency, I grant permission to have him/her treated by a designated ValleyCare Certified Athletic Trainer, any available doctor or dentist, or transported to the nearest local hospital. I hereby authorize the Livermore Valley Joint Unified School District to receive or to release pertinent information concerning my child.

_____ _____ _____
Signature of Student Athlete Signature of Parent/Guardian Date

Pre-participation Physical Evaluation

Athlete Physical (page 2 of 2)

Name: _____ Date of Birth: _____
Last First Middle

Height: _____ Weight: _____ Pulse: _____ BP _____/_____ (_____/_____ , _____/_____)

Vision R 20/_____ L 20/_____ Corrected: Yes / No Pupils: Equal ____ Unequal _____

	Normal	Abnormal Findings
MEDICAL		
Appearance		
Eyes/ears/nose/throat		
Hearing		
Lymph nodes		
Heart		
Murmurs		
Pulses		
Lungs		
Abdomen		
Genitourinary (male only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		

Immunizations ☐ Up to date (documentation on file at school) ☐ Not up to date Specify _____

☐ Cleared without restrictions

☐ Cleared, with recommendations for further evaluation or treatment for _____

☐ Not cleared for ☐ All sports ☐ Certain sports: _____ Reason _____

Recommendations: _____

_____

Name of Physician (print/type): _____ Date _____

Address _____ Phone _____

Signature of Physician: _____, MD or DO

*** AS PER CIF RULES, PHYSICALS MAY NOT BE PERFORMED BY A CHIROPRACTOR!***

Physician's Stamp: