

# PARTICIPATION IN EXTRACURRICULAR ACTIVITIES PHYSICAL EXAM FORM

School: \_\_\_\_\_

Grade: \_\_\_\_\_ ID# \_\_\_\_\_

Student's Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_  
 Address: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Family Dr: \_\_\_\_\_ Dr's Phone: \_\_\_\_\_

The above named student has my permission to participate in extracurricular activities and to travel with a representative of the school on any trips. In case of injury the school representative is authorized to have him/her treated or hospitalized by any one of the doctors cooperating with the school program. And I will not hold Grossmont Union High School District or its representatives responsible for payment as the result of any accident or injury.

**Medical History (to be completed by parent/guardian/caretaker)**

R or L Handed: \_\_\_\_\_ Allergies to medicines: \_\_\_\_\_

Has athlete had the following: Explain all "Yes" answers

- |  |           |          |  |
|--|-----------|----------|--|
| 1. Injuries to head, neck, bones, or joints              | Yes _____ | No _____ |  |
| 2. Any other injuries requiring medical attention        | Yes _____ | No _____ |  |
| 3. Seizures, blackouts or any episode of unconsciousness | Yes _____ | No _____ |  |
| 4. Heart trouble, Heart murmur, High Blood Pressure      | Yes _____ | No _____ |  |
| 5. Any serious infectious disease                        | Yes _____ | No _____ |  |
| 6. Hospitalizations or operations in the past            | Yes _____ | No _____ |  |
| 7. Stomach, Intestinal or Urinary Tract problems         | Yes _____ | No _____ |  |
| 8. Is the athlete taking any medicine on a regular basis | Yes _____ | No _____ |  |
| 9. Is the athlete under the care of a doctor now         | Yes _____ | No _____ |  |
| 10. Complex Dental problems                              | Yes _____ | No _____ |  |

Parent/Guardian/ Caregiver Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Emergency Contact if parents cannot be reached: \_\_\_\_\_ Phone: \_\_\_\_\_

**PHYSICAL EXAMINATION-** To be completed by Physician

Date: \_\_\_\_\_ Head: \_\_\_\_\_ Chest \_\_\_\_\_ (Including breasts)  
 Neck: \_\_\_\_\_ Back & Extremities: \_\_\_\_\_  
 Height: \_\_\_\_\_ Heart: \_\_\_\_\_ Abdomen: \_\_\_\_\_  
 Weight: \_\_\_\_\_ Lungs: \_\_\_\_\_ Genitalia: \_\_\_\_\_ (Including hernias)  
 Pulse: \_\_\_\_\_ Skin: \_\_\_\_\_  
 Blood Pressure: \_\_\_\_\_ Neurological: \_\_\_\_\_

General Appearance \_\_\_\_\_  
 From the above information and the screening physical exam, in my opinion this student  
 Is \_\_\_\_\_, is not \_\_\_\_\_ physically able to participate in competition.

Is further consultation necessary? Yes \_\_\_\_\_ No \_\_\_\_\_ Specialty \_\_\_\_\_

Signed: \_\_\_\_\_, MD Date: \_\_\_\_\_ Phone: \_\_\_\_\_

**Finance or Coaches Use Only:** ASB Card: \_\_\_\_\_ Physical: \_\_\_\_\_ Clearance: F W S  
 Physical Expires: \_\_\_\_\_

**Signed Parent Permission Form on File**

Purchased Insurance: \_\_\_\_\_ Has Personal Insurance \_\_\_\_\_  
 Football Only \_\_\_\_\_ CIF \_\_\_\_\_ Policy Carrier \_\_\_\_\_  
 Dental \_\_\_\_\_ 24 Hour \_\_\_\_\_ Policy Number \_\_\_\_\_

Student's Last Name)

(First)

(Middle)

# Sports Physicals

## **East County Urgent Care**

1625 Main Street #100

El Cajon, CA 92021

619-376-1082

Hours: M-F 8-5pm

Sat-Sun 9-3pm

Cost: \$30 to \$50

**No appointment necessary**

## **Dr. Wayne Moyer**

757 Broadway

El Cajon, CA 92021

619-442-3444

Hours: M-W-F 9-6pm

Tu-Th 9-12pm

Cost: \$25.00

**Call for appointment**

## **Doctors Express**

10538 Mission Gorge Road

Santee, CA 92071

619-456-0033

Hours: 8-8pm

Cost: \$50.00

**No appointment necessary**

## **Dr. Curry**

747 Jamacha Rd

El Cajon, CA 92019

619-593-7000

Cost: \$30.00

Call for appointment