

**BERKELEY UNIFIED SCHOOL DISTRICT
BERKELEY HIGH SCHOOL ATHLETIC DEPARTMENT**

California Interscholastic Federation By-Laws state that an annual physical examination, or a statement by a medical practitioner, certifying that the student is physically fit to participate in athletics is required before a student may try out, practice, or participate in interscholastic athletic competition.

**ANNUAL PHYSICAL EXAMINATION FOR PARTICIPATION IN ATHLETICS
PATIENT INFORMATION**

Student's Name _____ Date _____
 Address _____ Age _____
 Student's Birthdate _____ Home Phone _____
 Father's Work Phone _____ Extension _____
 Mother's Work Phone _____ Extension _____
 Family Physician _____ Phone _____
 Physician's Address _____ Zip _____
 Hospital Preference _____
 Family Dentist _____ Phone _____
 Medical Insurance _____ Medical No. _____

MEDICAL HISTORY

1. Have you ever had any injuries such as:

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Skull Fracture	<input type="checkbox"/>	<input type="checkbox"/>	Heat Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Painful Kneecap
<input type="checkbox"/>	<input type="checkbox"/>	Concussion	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Shinsplints
<input type="checkbox"/>	<input type="checkbox"/>	Knocked Out	<input type="checkbox"/>	<input type="checkbox"/>	Severe Dehydration	<input type="checkbox"/>	<input type="checkbox"/>	Trick knee
<input type="checkbox"/>	<input type="checkbox"/>	Arm/finger numbness	<input type="checkbox"/>	<input type="checkbox"/>	Broken bone, fracture	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain/injury
<input type="checkbox"/>	<input type="checkbox"/>	Deep bruise	<input type="checkbox"/>	<input type="checkbox"/>	Joint dislocation	<input type="checkbox"/>	<input type="checkbox"/>	Back pain/injury
<input type="checkbox"/>	<input type="checkbox"/>	Muscle tear or pull	<input type="checkbox"/>	<input type="checkbox"/>	Internal organ injury	<input type="checkbox"/>	<input type="checkbox"/>	Ligament sprain
<input type="checkbox"/>	<input type="checkbox"/>	Locking or catching joint	<input type="checkbox"/>	<input type="checkbox"/>	Leg/foot numbness	<input type="checkbox"/>	<input type="checkbox"/>	Other

Explain: _____

2. Do you have a history of any medical problems such as:

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma, allergy	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Tightness in chest	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Seizures/fainting	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Heart palpitations
<input type="checkbox"/>	<input type="checkbox"/>	Yellow jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Visual impairment	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Skin disease, boils	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Cold sores
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell disease	<input type="checkbox"/>	<input type="checkbox"/>	High/low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruiseability/bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Other

Explain: _____

3. Are you allergic to any medicines or environmental agents?

Yes No If Yes, explain: _____

4. Has anyone in your family under 50 years old died of heart problems or sudden unexplained causes?

Yes No If Yes, explain: _____

5. Have you ever been hospitalized?

Yes No If Yes, explain: _____

6. Have you ever had an operation or surgery?

Yes No If Yes, explain: _____

7. Have you ever had x-rays, worn a cast, splint or sling, or used crutches?

Yes No If Yes, explain: _____

8. Have you ever sustained an injury that prevented you from playing sports for more than one day?

Yes No If Yes, explain: _____