

VALLEY CHRISTIAN JUNIOR/SENIOR HIGH SCHOOL
Sports Physical Form

Year: 08/09
Grade (Fall 08) _____

Male [] Female []

Student's Name _____ Birth date _____
Address _____ Phone _____

California State Law requires evidence of Polio immunization and measles immunity (vaccine or disease) be on file within two weeks of admission to the district.

HEALTH DATA: To be filled in by parent or guardian. This report is confidential.

I. IMMUNIZATIONS AND TEST RECORD. Dates last given.

SMALLPOX VACCINATION _____ POLIO SALK _____ NUMBER RECEIVED _____
DIPHTHERIA-TETNUS (DT) _____ POLIO ORAL SABIN _____
POLIO ORAL TRIVALENT _____ CHEST X-RAY _____
TURBERCULIN TEST _____ REACTION _____ I _____ II _____ III _____
MEASLES VACCINE I _____ II _____
LIVE _____
KILLED I _____ II _____ RELIGIOUS EXEMPTION _____ MEDICAL EXEMPTION _____

II. HEALTH HISTORY (please check)

- | | |
|--|---|
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HERNIA |
| <input type="checkbox"/> MEASLES | <input type="checkbox"/> SCARLET FEVER |
| <input type="checkbox"/> SPEECH DIFFICULTY | <input type="checkbox"/> FREQUENT HEADACHES |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> FREQUENT NOSEBLEED |
| <input type="checkbox"/> EAR TROUBLE | <input type="checkbox"/> RECURRENT BOILS |
| <input type="checkbox"/> LAMENESS | <input type="checkbox"/> 4 OR MORE COLDS PER YEAR |
| <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> TIRES EASILY |
| <input type="checkbox"/> HEARING LOSS | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> ALLERGY | <input type="checkbox"/> FREQUENT LEG OR JOINT PAIN |
| <input type="checkbox"/> POLIOMYELITIS | <input type="checkbox"/> CEREBRAL PALSY |
| <input type="checkbox"/> DEFECTIVE VISION | <input type="checkbox"/> SHORTNESS OF BREATH |
| <input type="checkbox"/> PERSISTENT COUGH | <input type="checkbox"/> GERMAN MEASLES (3 DAY) |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> DIZZINESS OR BLACKOUTS |
| <input type="checkbox"/> WEARS GLASSES | <input type="checkbox"/> CHICKEN POX |

OTHER (Please Specify) _____

Has your son or daughter had contact with tuberculosis? Yes [] No []

If yes, to whom? _____ Last contact? _____

List any other serious illness, operation or injury and the age when this happened.

Has your son or daughter ever been advised not to participate in competitive athletics?

Yes [] No [] If yes, why? _____

DENTAL HISTORY: [] Dental bridge [] False teeth [] Orthodontia

III. ADJUSTMENT IN REGULAR PROGRAM

Do you feel that your son or daughter has any physical problems which would necessitate restriction in physical education? Yes [] No []

Explanation: _____

IV. PROFESSIONAL HEALTH CARE

Name of physician _____ Date of last visit _____

Name of dentist _____ Date of last visit _____

Please add any other information that might help nurse and teachers assist your child in his/her adjustment to school life. _____

I hereby give my permission for my son or daughter to participate fully in the school athletic program.

PHYSICIANS FINDINGS AND RECOMMENDATIONS

I. FINDINGS

Heart: (a) Murmurs: No Yes Describe _____
(b) Rhythm _____
(c) Pulse Rate: At rest after exercise: _____
Recovery Rate: Satisfactory _____ Unsatisfactory _____
(d) Blood Pressure: _____
Height: _____
Weight _____
Hernia: _____
Urinalysis: _____
Tetanus toxide given (date): _____

II. RECOMMENDATIONS

In my opinion, this student may participate in all inter-school competitive sports.
 In my opinion, this student may participate in all inter-school competitive sports except:

FOR PHYSICAL EDUCATION (Check)

- 1. Any activity including competitive intramural and inter-school games.
- 2. Any activity except swimming.
- 3. Regular physical education without intramural and/or inter-school games.
- 4. Modified physical education. Activities organized to fit individualized needs.

Modifications and comments: _____

REASON FOR MODIFICATIONS: _____

DURATION OF MODIFICATIONS (Check)

- 1 week 2 weeks 1 month 2 months
- 6 months semester year

FOR ACADEMIC PROGRAM (Check)

- Lip reading instruction Speech correction
- Home instruction teacher Reduction of pressure in class work
- Help in social adjustment
- Better adjustments of academic program to student interest and capability
- OTHER ADJUSTMENTS AND COMMENTS: _____

Date: _____ Physician's Signature _____