



Athletic Participation and Physical Examination Form

The Quarry Lane School, 6363 Tassajara Road, Dublin, CA 94568
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PLEASE UPLOAD THIS FORM TO THE PARENT PORTAL ONLY. THIS FORM WILL NOT BE ACCEPTED IN ANY OF THE SCHOOL OFFICES.

PART 1: History (to be completed by student and parent or guardian)

Student Name: _____ Grade: _____ Birthdate: _____ Sex: M F
Address: _____ City: _____ Zip: _____
Sport(s): _____
Emergency Contact: _____ Relationship: _____
Home Phone: _____ Work Phone: _____ Mobile Phone: _____
Doctor's Name: _____ Phone: _____
Health Insurance Carrier: _____ Policy #: _____

Health History (must be completed prior to examination)

Has this student had any history of:

- Yes No Hospitalization?
- Yes No Surgery other than removal of tonsils?
- Yes No Missing organs (eye, kidney, testicle)?
- Yes No Allergies (medicines, insects, food)?
- Yes No Chest pain or severe shortness of breath?
- Yes No Problems w/blood pressure or heart (heart murmur)?
- Yes No Dizziness or fainting with exercise?
- Yes No Severe or frequent headaches?
- Yes No Concussion or loss of consciousness?
- Yes No Heat exhaustion, heat stroke or other problems with heat?
- Yes No Mononucleosis, hepatitis, hemophilia?
- Yes No Diabetes?
- Yes No Seizures/convulsions?
- Yes No Dislocation of a joint?
- Yes No Catching or clicking of a joint?
- Yes No Broken bones/fractures?
- Yes No Stingers/burners or pinched nerves?
- Yes No Ulcers or hernias?
- Yes No Skin problems?
- Yes No Head injury?
- Yes No Neck or back injury?
- Yes No Chest injury?
- Yes No Shoulder/upper arm injury?
- Yes No Elbow/forearm injury?
- Yes No Hand, wrist or finger injury?
- Yes No Hip/thigh injury?
- Yes No Knee injury?
- Yes No Shin/calf injury?
- Yes No Ankle/foot injury?
- Yes No Has any family member or relative died of heart problems or of sudden death before age 50?

Date of last known Tetanus shot: _____

FEMALES ONLY

When was your first menstrual period? _____
When was your most recent menstrual period? _____
How much time do you usually have from the start of one period to the start of another? _____
How many periods have you had in the last year? _____
What was the longest time between periods in the last year?

Use the back of this sheet to explain any "Yes" answers to the Health History questions and to list any other pertinent information.

PART 2: Parental Waiver

I have reviewed and agree with the information presented on this form. I also understand that this examination is primarily for sports participation screening and is not intended to replace the routine health care visits as recommended by the student's personal physician. I know of no reason why the above-named student should not participate and represent his or her school in supervised athletic activities. I am aware that with the participation in sports comes the risk of injury and that the degree of danger and the seriousness of risk vary from one sport to another. I am aware that The Quarry Lane School, its employees and volunteers are in no way responsible for any injuries that my child/ward might incur as a result of such participation and agree to release The Quarry Lane School, its employees and volunteers from any legal liability and agree not to sue for any and all injuries. I will indemnify, defend and hold harmless The Quarry Lane School, its officers, directors, employees and agents from and against any and all claims, expenses, including attorney's fees, losses, suits or judgments arising from or in connection with or relating to my child/ward's participation in athletics. In the event of an emergency, if I can not be reached, I give consent for the coach, athletic trainer, or school authorities to obtain medical care, including ambulance, as is reasonably necessary for the welfare of my child/ward. With this knowledge in mind, I grant permission for my child/ward to participate in athletics.

PRINT Parent/Guardian Name: _____
Parent/Guardian Signature: _____ Date: _____
Home Phone: _____ Work Phone: _____ Mobile Phone: _____
Email: _____

PART 3: Physical Examination (to be completed by examining physician)

	Normal	Abnormal (Describe)	
Eyes, Ears, Nose, Throat			Pulse _____
Skin			BP _____
Lungs			Height _____
Heart			Weight _____
Abdomen			Visual Acuity:
Genitalia/Hernia (Males)			R _____
			L _____

SUGGESTED MUSCULOSKELETAL EXAM

ROM/STRENGTH

Cervical

- NL AB Flex/Ext
- NL AB Rotation right/left
- NL AB Lateral flexion right/left

Thoracic/Lumbar

- NL AB Flex/Ext
- NL AB Rotation right/left
- NL AB Lateral flexion right/left
- NL AB Abdominals/Obliques

Shoulder

- NL AB Forward flexion/ext
- NL AB Abduction/Adduction
- NL AB Internal/Ext rotation
- NL AB Horizontal Abd/Add
- NL AB A-C Joint/Clavicle
- NL AB Stability Testing
- NL AB Biceps flex/ext
- NL AB Elbow supination/pronation
- NL AB Wrist/Hand

Hip

- NL AB Hip flexors/gluteals
- NL AB Add/Abd-groin/IT Band
- NL AB Int/Ext rotation

Knee

- | | |
|---|------------------------|
| <input type="checkbox"/> NL <input type="checkbox"/> AB | Patellar tendon |
| <input type="checkbox"/> NL <input type="checkbox"/> AB | Tibial tuberosity |
| <input type="checkbox"/> NL <input type="checkbox"/> AB | MCL/LCL |
| <input type="checkbox"/> NL <input type="checkbox"/> AB | ACL/PCL |
| <input type="checkbox"/> NL <input type="checkbox"/> AB | Cartilage testing |
| <input type="checkbox"/> NL <input type="checkbox"/> AB | Quads/Hamstrings |
| <input type="checkbox"/> NL <input type="checkbox"/> AB | Gastroc/Soleus complex |
| <input type="checkbox"/> NL <input type="checkbox"/> AB | Patella crepitus |
| <input type="checkbox"/> NL <input type="checkbox"/> AB | Patella tracking |

Ankle

- | | |
|---|---------------------|
| <input type="checkbox"/> NL <input type="checkbox"/> AB | Plantar/Dorsi exion |
| <input type="checkbox"/> NL <input type="checkbox"/> AB | Inversion/Eversion |
| <input type="checkbox"/> NL <input type="checkbox"/> AB | Subtalar joint |
| <input type="checkbox"/> NL <input type="checkbox"/> AB | Ligament Testing |
| <input type="checkbox"/> NL <input type="checkbox"/> AB | Feet/Toes |

General Flexibility

- | | |
|---|--------------|
| <input type="checkbox"/> NL <input type="checkbox"/> AB | Hamstrings |
| <input type="checkbox"/> NL <input type="checkbox"/> AB | Quadriceps |
| <input type="checkbox"/> NL <input type="checkbox"/> AB | Lumbar spine |
| <input type="checkbox"/> NL <input type="checkbox"/> AB | Achilles |

Describe Abnormals: _____

DISPOSITION:

Cleared for collision, contact and non-contact sports: Yes No

Conditional participation, limited to: _____

No participation until: _____

No participation in any sport because of: _____

Comments: _____

Date: _____

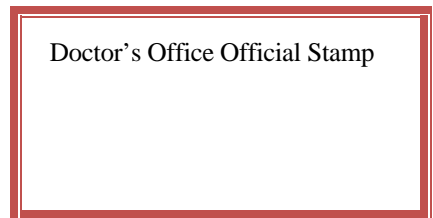
Physician's Signature: _____

Physician's Name: _____

License #: _____

Address: _____

Phone: _____



* Not Valid Without Stamp*