## CARLSBAD HIGH SCHOOL PHYSICAL EXAM/ATHLETIC ELIGIBILITY FORM

NAME: (Last Name)	111131				GRADE			
(Last Name)	e) (First Name		First Name)	(Initial)				
ADDRESS								
·					_LIVESWITH:PARENTGUARDIAN			
HOME PHONE:	FATHER'S WORK:			MOTHER'S WORK:				
FAMILY PHYSICIAN:				PHONE:				
				EXAMINATION				
MEDICAL HISTORY (to be completed by parent/guardian)								
		YES	NO			YES	NO	
Family history of sudden death?			,	Dental Implants?				
Chronic/recurrent illness?				Cough/pain?				
Hospitalization?				Problems w/blood pressure?				
Surgery other than tonsils?				Problems w/heart - murmurs?				
Injuries treated by doctor?				Problem w/liver, kidney, or spleen	1?			
Current medications?				Hernia?				
Organs missing?				Recurrent skin disease?				
Heat stroke/exhaustion?				Bone/joint injury?				
Dizziness, fainting?				Sprain/dislocation?				
Convulsions?				Allergic to any medications?				
Knocked out/concussion?				Injury causing missed practice or g	game time?			
Glasses or contacts?				Tetanus shot in last ten years?				
Hearing defects/deficiency?	_							
If you answered yes to any of t	he above, please	e explair	1:					
	_							
=								
EXAM (to be completed by p	•							
Height:	Weight:				Blood Pressure:			
MEDICAL	NORM		ABN	MUSCLOSKELETAL	NORM	<del></del>	ABN	
Appearance Eye/Ear/Nose/Throat		-		Neck Back		-		
Lymph Nodes	-	_		Shoulder/Arm				
Heart		+		Elbow/Forearm		+		
Pulses				Wrist/Hand				
Lungs				Hip/Thigh				
Abdomen				Knee				
Genitalia				Leg				
Skin		l		Foot/Ankle				
				Cleared:	Not Cle	ared:		
Physician Signature			Dat	e				
	WA	DNING	OF DISK AN	ID TREATMENT CONSENT				
Participation in competitive athleti				paralysis and even death. Changes i	n rules improved o	onditioni	no nroorams	
				risks. HOWEVER, IT IS IMPOSSII				
				ry by obeying the rules of their spor				
following a proper conditioning pro	ogram and inspec	ting their	equipment de	aily. Damaged equipment must be re	placed. Even if all	of these re	equirements	
				t, a serious injury may still occur. W				
				VOLVED WITH THE PARTICIPA				
				NGER AND THE POTENTIAL OF				
attention Thereby grant permission	TE ATHLETIC P	KUUKA	ivi A I CAKLi r health care m	SBAD HIGH SCHOOL. In the even professional, designated by the Certif	it of an emergency i	equiring:	iledical	
attend to my child. I expect that ev	erv effort will be	made to	contact me in	order to receive my specific authorize	zation or instruction	s hefore :	ny treatment	
				AND in compliance with California				
				ospital treatment which will be in eff				
my student/athlete.		<b>3</b>			5	. F		
<u></u>					<b></b>			
Insurance Company				l l	Policy Number			
74 1 4 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2				D 110 11 01				
Student Name (Print)		Stud	lent Signat	ure I	Parent/Guardian Signature			