

## C.I.F Athletics Participation Health Form

**Student Information** (to be completed by student—parent signature required at bottom)

Name \_\_\_\_\_  
Last First

Address \_\_\_\_\_  
Street City Zip Phone

**History**

1. Have you ever had (circle if yes) allergies \_\_\_\_\_ asthma \_\_\_\_\_ seizures \_\_\_\_\_ heart murmur \_\_\_\_\_  
a broken bone \_\_\_\_\_ diabetes \_\_\_\_\_ surgery \_\_\_\_\_ admission to a hospital \_\_\_\_\_
2. Do you wear corrective lenses during sports? Yes \_\_\_\_\_ No \_\_\_\_\_
3. Is your hearing normal? Yes \_\_\_\_\_ No \_\_\_\_\_
4. Do you take medication? Yes \_\_\_\_\_ No \_\_\_\_\_
5. Please note any other medical information that school personnel may need \_\_\_\_\_

**Parent Permission** for exam \_\_\_\_\_  
Parent/Guardian signature Date

**Physician Information**—to be completed by physician or nurse practitioner only

**Physical Examination**

Height \_\_\_\_\_ Weight \_\_\_\_\_ B.P. \_\_\_\_\_ / \_\_\_\_\_ Pulse \_\_\_\_\_

Code: 0=Negative X=Positive NE=No Examination

1. Ears, Nose, Throat		8. Musculoskeletal evaluation	
2. Eyes—pupil equal reactive		8.1 Flexibility/stability of joints	
Symmetry of eye movement		Gait                  Hand	
3. Dental—missing teeth		kneebend	
Chipped teeth		8.2 Spine—scoliosis	
Removeable teeth		8.3 Swelling of any joint	
Orthodontia		8.4 Muscular weakness	
4. Lungs		8.5 Atrophy	
5. Heart		Thigh                  Shoulder girdle	
6. Abdomen		Calf                      Arm	
7. Hernia		9. Incoordination/loss of balance	

Additional findings, comments and/or recommendations \_\_\_\_\_

“I certify that I have on this date examined this student and that, on the basis of the exam requested by the school authorities and the student’s medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities.”

**If student is not medically fit to participate in athletics or if there are exceptions to the above statement, examining physician should indicate above.**

Signature of Examining Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Print Name \_\_\_\_\_ Date \_\_\_\_\_ Agency \_\_\_\_\_