

MBUSD – Mira Costa High School

Pre-participation Physical Evaluation

Female ___ Male ___
Year 2021-2022

Print Last Name Grade	First Name	Middle Initial Sport	Date of Birth
Address		City	Zip
			Home Phone Number
Did you transfer from another high school? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, list date, name, city and state of last high school attended.			
Father/Guardian's Name		Father/Guardian's Phone Number	Mother/Guardian's Name
			Mother/Guardian's Phone No.
Father's Work Number		Mother's Work Number	Others to Call in Emergency (Name and Phone Number)

HEALTH HISTORY (To be completed by student & parent): Check "yes" or "no" and give as much information as possible.

Yes No Heart Trouble
 Yes No Asthma
 Yes No Diabetes
 Yes No Seizures
 Yes No Palpitations
 Yes No Fatigue
 Yes No High Blood Pressure
 Yes No Chest Pain
 Yes No Current Skin Condition
 Yes No Dizziness/Fainting
 Yes No Extreme Shortness of Breath/Wheezing
 Yes No Kidney Problems
 Yes No History of family member with heart attack under 50yrs of age or sudden death.
 Yes No Other: Glasses/Contacts, Protective Equipment, or Hearing Aid
 Yes No Head Trauma/Loss of Consciousness

Other: _____

History of any previous injuries, fractures, serious illnesses or operations/hospitalizations (describe and give approximate dates)

Current medications	Allergies	Date of Last Tetanus Shot
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PARENT CONSENT

I hereby state that the above information is true and correct and give my consent for the above-named student to compete in sports and go with a representative of the school on any trips. In case of injury, the school representative is authorized to have him/her treated.

▶ _____	▶ _____	▶ _____	▶ _____
Date	Parent/Guardian Signature	Name of Insurance Co.	Policy/Group No.

PHYSICAL EXAMINATION (To be completed by physician):

Visual Acuity (Distance): O.D. ____/____ O.S. ____/____ () Corrected () Uncorrected

Height _____ Weight _____ Blood Pressure _____ Pulse _____

	Normal		Normal
1. Eyes, Ears, Nose, Throat		9. Musculoskeletal	
2. Neck		Neck	
3. Cardiovascular		Spine	
EKG results (if done)		Shoulders	
4. Chest and Lungs		Arms/Hands	
5. Abdomen		Hips	
6. Skin		Thighs	
7. Genitalia-Hernia (male)		Knees	
8. Neuromuscular		Ankles	
		Feet	

Comments: _____

RECOMMENDATION:
 () Full Activity – No restrictions
 () Activity with restrictions: _____
 () No contact sports
 () No Participation
 () Other _____

EXAMINING PHYSICIAN: _____ DATE OF EXAM: ▶ _____

Print name: ▶ _____ Signature: ▶ _____ LICENSE #: ▶ _____

Print or Stamp Address: ▶ _____ Phone: ▶ _____