

School Site: _____

Sacramento City Unified School District

PART 1 (TO BE COMPLETED BY A PARENT OR LEGAL GUARDIAN)

LAST NAME		FIRST NAME			GRADE
BIRTHDATE	FALL SPORT	WINTER SPORT	SPRING SPORT	STUDENT ID NUMBER	

PART 1 -- HEALTH HISTORY (Must be Completed by Parent/Guardian Pri or to the Examination)

	Yes	No	Has this student had				
1.	†	†	Chronic or recurrent illness?	16.	†	†	Injuries requiring medical care or treatment?
2.	†	†	Illness lasting over 1 week?	17.	†	†	Neck or back pain or injury?
3.	†	†	Hospitalizations or Surgeries?	18.	†	†	Knee pain or injury?
4.	†	†	Nervous, psychiatric, or neurologic condition?	19.	†	†	Shoulder or elbow pain or injury?
5.	†	†	Loss or nonfunctioning of organs (eye, kidney, liver, testicle) or glands?	20.	†	†	Ankle pain or injury?
				21.	†	†	

PRINT NAME OF PARENT OR GUARDIAN		SIGNATURE OF PARENT OR GUARDIAN		
ADDRESS		WORK PHONE	HOME PHONE	DATE
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PART 2 -- MEDICAL EVALUATION (TO BE COMPLETED BY THE EXAMINING HEALTH CARE PROVIDER)

This Evaluation Can Only be Performed by Medical Doctors (MDs), DoW R U V R I 2 V W H R S D W K \ ' 2 V 3 K \ V L F L D Q ¶ V \$ V V L V W D Q W V

	NORMAL	ABNORMAL (Describe)	0 D \ E H F R Q W D L Q H G R Q
Eyes/Ears/Nose/Throat			Height: Weight:
Heart, lungs, pulmonary function			Pulse After Ex:
Abdomen, genital/hernia (males)			BP:
Skin and Musculoskeletal:			Recommendation: <input type="checkbox"/> Unlimited participation <input type="checkbox"/> Limited participation/specific sports, events or activities <input type="checkbox"/> Clearance withheld pending further testing/evaluation <input type="checkbox"/> No athletic participation One of the above MUST be checked
a. Neck/Spine/Shoulders/Back			
b. Arms/Hands/Fingers			
c. Hips/Thighs/Knees/Legs			
d. Feet/Ankles			
Neurologic Screening Exam (NSE)/ Concussion Screening Evaluation (only if needed based on above info.)			