

**C.I.F. ATHLETIC PARTICIPATION HEALTH FORM**  
**LAS VIRGENES UNIFIED SCHOOL DISTRICT**  
**HEALTH SERVICES**

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**STUDENT INFORMATION** – To be completed by student – Parent/Guardian signature required

Last name:	First name:
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**HISTORY: (check yes or no)**

YES	NO	ILLNESS	YES	NO	ILLNESS	YES	NO	ILLNESS
		Allergy/Asthma			Glasses/Contacts			Mononucleosis
		Arthritis			Heart Murmur			Mumps
		Chicken Pox			Hepatitis			Pneumonia
		Concussion			Hernia			Polio
		Diabetes			Kidney problems			Rheumatic fever
		Epilepsy/Seizures			Measles			Tuberculosis
		Fainting (frequent)			Migraine headache			Whooping cough

1. Please note any other medical information that school personnel may need \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**ORIGINAL MUST BE RETURNED TO SCHOOL – NO COPIES**

**PHYSICIAN INFORMATION – To be completed by Physician or Nurse Practitioner only.**

Weight:	B.P.	Pulse:
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**Code: 0 – Negative      X = Positive      NE: = No Examination**

Ear, Nose, Throat		8. Musculoskeletal evaluation	
Eyes – pupil equal reactive		8.1 Flexibility/stability of joints	
- Symmetry of eye movement		- Gait      - hand	
Dental – missing teeth		- Knee bend	
- chipped teeth		8.2 Spine: Scoliosis	
- removable teeth		8.3 Swelling of any joint	
- orthodontia		8.4 Muscular weakness	
Lungs		8.5 Atrophy	
Heart		- Thigh      -shoulder girdle	
Abdomen		- Calf      -arm	
Hernia		9. In coordination/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 of Physical: \_\_\_\_\_ Date: \_\_\_\_\_

(Good for one calendar year)

\*STAMP REQUIRED HERE

**Please note:** Physical done by school doctors at the annual school-wide physicals do not replace your child’s regular annual check-up with your primary care physician.