 Approved 5.2021

LVUSD C.I.F. Athletic Participation Health Form

Both pages of this form must be uploaded to your AthleticClearance.com registration. For more info visit agouraathletics.net

Date of Exam: ____________________________ (Valid for one calendar year) Date of Birth: ___________________________

Name of Student: ____ Graduation Year: _________________________________

To be completed by Parent/Student. Explain "Yes" answers at the bottom, and circle questions you don't know answers to.

Yes No

1. Y N Has a doctor ever denied or restricted your participation in sports for any reason?
2. Y N Do you have an ongoing medical condition (like diabetes or asthma)?
3. Y N Are you currently taking prescription or non-prescription (over-the-counter) medicines or pills? Are you currently prescribed an Inhaler?
4. Y N Do you have allergies to medicines, stinging insects, or food requiring an epinephrine auto injector?
5. Y N Do you have allergies to pollen or foods not needing an epinephrine auto injector?
6. Y N Have you ever passed out or nearly passed out DURING exercise?
7. Y N Have you ever passed out or nearly passed out AFTER exercise?
8. Y N Have you ever had discomfort, pain, or pressure in your chest during exercise?
9. Y N Does your heart race or skip beats during exercise?
10. Circle all that apply: Has a doctor told you that you have
    High Blood Pressure High Cholesterol
    A heart murmur A heart infection
11. Y N Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)
12. Y N Has anyone in your family died for no apparent reason?
13. Y N Does anyone in your family have a heart problem?
14. Y N Has any family member or relative died of heart problems or of sudden death before age 50?
15. Y N Does anyone in your family have Marfan syndrome?
16. Y N Have you ever spent the night in a hospital?
17. Y N Have you ever had surgery?
18. Y N Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?
19. Y N Do you regularly use a brace or assistive device?
20. Have you ever had or have any of the following, put a **C** for current and **P** for previous.

	Sprain/ Strain	Tendonitis	Broken/ Fractured	Stress Fracture	Dislocated
Elbow					
Upper Back					
Knee					
Neck					
Forearm					
Lower Back					
Calf/Shin					
Shoulder					
Hands/ Fingers					
Hip					
Ankle					
Upper Arm					
Chest					
Thigh					
Foot/Toes					

☐ None of the above apply

Yes No

21. Y N Have you been diagnosed with COVID - 19? Date:_________
22. Y N Has a doctor ever told you that you have asthma?
23. Y N Do you cough, wheeze, or have difficulty breathing during or after exercise?
24. Y N Is there anyone in your family who has asthma?
25. Y N Have you ever used an inhaler or taken asthma medicine?
26. Y N Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?
27. Y N Have you had infectious mononucleosis (mono) within the last month?
28. Y N Do you have any rashes, pressure sores, or other skin problems?
29. Y N Have you had a herpes skin infection?
30. Y N Have you ever had a head injury or concussion?
31. Y N Have you been hit in the head and been confused or lost your memory?
32. Y N Have you ever had a seizure?
33. Y N Do you have headaches with exercise?
34. Y N Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?
35. Y N Have you ever been unable to move your arms or legs after being hit or falling?
36. Y N When exercising in the heat, do you have severe muscle cramps or become ill?
37. Y N Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?
38. Y N Have you had any problems with your eyes or vision?
39. Y N Do you wear glasses or contact lenses?
40. Y N Do you wear protective eyewear, such as goggles or a face shield?
41. Y N Are you happy with your weight?
42. Y N Are you trying to gain or lose weight?
43. Y N Has anyone recommended you change your weight or eating habits?
44. Y N Do you limit or carefully control what you eat?
45. PHQ-4 Questionnaire

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly Everyday
1.Feeling nervous, anxious or on edge	0	1	2	3
2.Not being able to stop or control worrying	0	1	2	3
3. Feeling down, depressed or hopeless	0	1	2	3
4.Little interest or pleasure in doing things	0	1	2	3

A score of ≥3 for question 1 and 2 or question 3 and 4 is positive for screening purposes

46. Y N Do you have any concerns that you would like to discuss with a doctor?

Females Only

47. Y N Have you ever had a menstrual period?
48. How old were you when you had your first menstrual period?_________
49. How many periods have you had in the last 12 months? ____________

Explain any "Yes" answers here:

____

____

____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Athlete_________________________ Signature of Parent/Guardian _________________________ Date__________

Student Name: ________________________________

Physical Evaluation (Completed by Physician)

Height:____________Weight:___________ Pulse:__________ BP:_______/_______ (_____/_____)

Pupils: Equal Unequal Vision R: 20/____ L: 20/_____ Corrected: Y N % Body Fat_________

******Please review the history questionnaire on Page 1 before signing this clearance form ******

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only. +Having a third party present is recommended for the genitourinary examination

Notes:____

Recommendations:____

☐ **Cleared without restriction** ☐ **Not Cleared**

Name of physician: (print)________________________________ Date of Physical: ________________

(Good for one calendar year)

Signature of physician:____________________________________ Date: _______________________

Please note: Physicals done on campus or through team physicians, EXER, CVS Minute Clinic, or any other Urgent Care Facility do NOT replace your child's regular annual check-up with your primary care doctor.

DOCTORS OFFICE STAMP REQUIRED HERE: