2011 - 2012 Physical Screening and Physician Authorization Form

This is not a Capistrano Unified School District sponsored event

Not printed at CUSD expense

Student's Legal Name: ______________________ Home Phone Number: ______________

Home Address: ______________________ Date of Birth: ______________

School Group: ______________________ Age: ______________

Your Medical History:

Answer the following questions prior to the appointment with the Doctor. "Yes" answers require a detailed explanation.

1. Have you ever sustained an injury which prevented you from playing sports for more a day? **Yes** **No**
2. Are you allergic to any medication? **Yes** **No** (describe) ______________________
3. Do you have any family history of medically unexplained or cardiac caused sudden death under age 50? **Yes** **No**
4. Do you have any family history of Long QT Syndrome or unexplained fainting or seizures? **Yes** **No**
5. Females Only – Dates of most recent menstrual period: ______________
6. Have you had any injuries, pain or swelling to the following areas? (Circle all that apply)

Head **Chest** **Elbows** **Hands** **Hips** **Knees** **Ankles** **Neck** **Arms** **Shoulders** **Wrists**

Fingers **Thighs** **Shins** **Calves** **Feet** **Back** **Other:** ______________

7. Do you have a history of and/or take medication for any medical problem listed below (Circle all that apply)

Viral Infections	**Heart Conditions**	**Asthma**	**Easily tired**	**Dizziness**	**High or Low Blood Pressure**
Illness from Heat	**Chest Pain**	**Seizures**	**Rash or Hives**	**Fainting**	**High or Low Cholesterol**
Difficulty Breathing	**Broken Bones**	**Diabetes**	**Hospitalization**	**Allergies**	**Severe Headaches**
Skin Conditions	**Concussion**	**Numbness**	**Joint Pain**	**Surgery**	**Any other Conditions**

Other: ____

I, (print name) ______________________, give my consent on behalf of my son/daughter (or the minor for whom I am legal guardian), as named above, to participate in and receive a physical screening exam. This exam may include an unclothed exam by a licensed health provider as well as urine, vision, & blood pressure screening. I understand that this examination is intended for the purpose of screening for participation in the We Run Orange County's Kids marathon training program. I also consent to the release of information by the screening institution to representatives of We ROCK. I also hereby state that, to the best of my knowledge, my answers to the questions above are complete and correct.

Parent/Guardian Signature: ______________________________ Date: ______________

For Physician Use Only: (Please complete, sign, date and affix your stamp)

Height: _________ Weight: _________ B/P: _________ Pulse: ________ Temperature:________ Respiration: _________

Please circle any areas of concern:

Eyes **Ears** **Neck** **Back** **Nose** **Shoulders** **Throat** **Elbows** **Hands** **Wrists** **Skin**

Arms **Forearms** **Legs** **Ankles** **Lungs** **Pulse** **Hips** **Thighs** **Heart** **Knees** **Hernia**

Abdomen **Feet** **Lymph Nodes** **Blood Pressure** **Other:** ______________

Screening Results (please circle): **Satisfactory** **Recommend Further Evaluation** (Reason: ______________)

May this individual continue to train and participate in the We ROCK program? **Yes** **No**

Physician Signature: Date:

Physician Name (print): Stamp: