

VALLEY CHRISTIAN JUNIOR/SENIOR HIGH SCHOOL  
Sports Physical Form

Year: \_\_\_\_\_  
Grade Fall \_\_\_\_\_

Male  Female   
Student's Name \_\_\_\_\_ Birth date \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

California State Law requires evidence of Polio immunization and measles immunity (vaccine or disease) be on file within two weeks of admission to the district.

HEALTH DATA: To be filled in by parent or guardian. This report is confidential.

I. IMMUNIZATIONS AND TEST RECORD. Dates last given.

SMALLPOX VACCINATION \_\_\_\_\_ POLIO SALK \_\_\_\_\_ NUMBER RECEIVED \_\_\_\_\_  
DIPHTHERIA-TETNUS (DT) \_\_\_\_\_ POLIO ORAL SABIN \_\_\_\_\_  
POLIO ORAL TRIVALENT \_\_\_\_\_ CHEST X-RAY \_\_\_\_\_  
TURBERCULIN TEST \_\_\_\_\_ REACTION \_\_\_\_\_ I \_\_\_\_\_ II \_\_\_\_\_ III \_\_\_\_\_  
MEASLES VACCINE I \_\_\_\_\_ II \_\_\_\_\_  
LIVE \_\_\_\_\_  
KILLED I \_\_\_\_\_ II \_\_\_\_\_ RELIGIOUS EXEMPTION \_\_\_\_\_ MEDICAL EXEMPTION \_\_\_\_\_

II. HEALTH HISTORY (please check)

- |  |   |
|--|---|
| <input type="checkbox"/> ASTHMA            | <input type="checkbox"/> HERNIA                     |
| <input type="checkbox"/> MEASLES           | <input type="checkbox"/> SCARLET FEVER              |
| <input type="checkbox"/> SPEECH DIFFICULTY | <input type="checkbox"/> FREQUENT HEADACHES         |
| <input type="checkbox"/> DIABETES          | <input type="checkbox"/> FREQUENT NOSEBLEED         |
| <input type="checkbox"/> EAR TROUBLE       | <input type="checkbox"/> RECURRENT BOILS            |
| <input type="checkbox"/> LAMENESS          | <input type="checkbox"/> 4 OR MORE COLDS PER YEAR   |
| <input type="checkbox"/> EPILEPSY          | <input type="checkbox"/> TIRES EASILY               |
| <input type="checkbox"/> HEARING LOSS      | <input type="checkbox"/> TUBERCULOSIS               |
| <input type="checkbox"/> ALLERGY           | <input type="checkbox"/> FREQUENT LEG OR JOINT PAIN |
| <input type="checkbox"/> POLIOMYELITIS     | <input type="checkbox"/> CEREBRAL PALSY             |
| <input type="checkbox"/> DEFECTIVE VISION  | <input type="checkbox"/> SHORTNESS OF BREATH        |
| <input type="checkbox"/> PERSISTENT COUGH  | <input type="checkbox"/> GERMAN MEASLES (3 DAY)     |
| <input type="checkbox"/> RHEUMATIC FEVER   | <input type="checkbox"/> DIZZINESS OR BLACKOUTS     |
| <input type="checkbox"/> WEARS GLASSES     | <input type="checkbox"/> CHICKEN POX                |

OTHER (Please Specify) \_\_\_\_\_

Has your son or daughter had contact with tuberculosis? Yes  No   
If yes, to whom? \_\_\_\_\_ Last contact? \_\_\_\_\_  
List any other serious illness, operation or injury and the age when this happened.

Has your son or daughter ever been advised not to participate in competitive athletics?  
Yes  No  If yes, why? \_\_\_\_\_

DENTAL HISTORY:  Dental bridge  False teeth  Orthodontia

III. ADJUSTMENT IN REGULAR PROGRAM

Do you feel that your son or daughter has any physical problems which would necessitate restriction in physical education? Yes  No   
Explanation: \_\_\_\_\_

IV. PROFESSIONAL HEALTH CARE

Name of physician \_\_\_\_\_ Date of last visit \_\_\_\_\_  
Name of dentist \_\_\_\_\_ Date of last visit \_\_\_\_\_

Please add any other information that might help nurse and teachers assist your child in his/her adjustment to school life. \_\_\_\_\_

I hereby give my permission for my son or daughter to participate fully in the school athletic program.

## PHYSICIANS FINDINGS AND RECOMMENDATIONS

### I. FINDINGS

Heart: (a) Murmurs: No  Yes  Describe \_\_\_\_\_  
(b) Rhythm \_\_\_\_\_  
(c) Pulse Rate: At rest after exercise: \_\_\_\_\_  
Recovery Rate:  Satisfactory \_\_\_\_\_  Unsatisfactory \_\_\_\_\_  
(d) Blood Pressure: \_\_\_\_\_  
Height: \_\_\_\_\_  
Weight \_\_\_\_\_  
Hernia: \_\_\_\_\_  
Urinalysis: \_\_\_\_\_  
Tetanus toxide given (date): \_\_\_\_\_

### II. RECOMMENDATIONS

In my opinion, this student may participate in all inter-school competitive sports.  
 In my opinion, this student may participate in all inter-school competitive sports except:

\_\_\_\_\_

#### FOR PHYSICAL EDUCATION (Check)

- 1. Any activity including competitive intramural and inter-school games.
- 2. Any activity except swimming.
- 3. Regular physical education without intramural and/or inter-school games.
- 4. Modified physical education. Activities organized to fit individualized needs.

Modifications and comments: \_\_\_\_\_  
\_\_\_\_\_

REASON FOR MODIFICATIONS: \_\_\_\_\_

#### DURATION OF MODIFICATIONS (Check)

- 1 week     2 weeks     1 month     2 months
- 6 months     semester     year

#### FOR ACADEMIC PROGRAM (Check)

- Lip reading instruction                       Speech correction
- Home instruction teacher                       Reduction of pressure in class work
- Help in social adjustment
- Better adjustments of academic program to student interest and capability
- OTHER ADJUSTMENTS AND COMMENTS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Physician's Signature \_\_\_\_\_