CPF-2

NATOMAS UNIFIED SCHOOL DISTRICT

2024-25 SPORTS PHYSICALEXAMINATIONFORM

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

STUDENT LAST NAME:		STUDENT FIRST NAME:		ID #:
GRADE:	BIRTHDATE:	FALL SPORT:	WINTER SPORT:	SPRING SPORT:

HEALTH HISTORY (Must be Completed Prior to the Examination)

YES	***NO***	***Has this student had any:***		***YES***	***NO***	***Does this student:***
		1 Chronic or recurrent illness?				16 Wear eyeglasses or contact lenses?
		2 Illness lasting over 1 week?				17 Wear dental bridges, braces or plates?
		3 Hospitalization or Surgeries?				18 Take any medications? (List below):
		4 Nervous, psychiatric, or neurologic condition?				
		5 Loss or nonfunctioning of organs (eye, kidney, liver, testicle) or glands?		***YES***	***NO***	***Is there any history of:***
		6 Allergies (medicines, insect bites, food)?				19 Injuries requiring medical care or treatment?
		7 Problems with heart or blood pressure?				20 Neck or back pain or injury?
		8 Chest pain or severe shortness of breath with exercise?				21 Knee pain or injury?
		9 Dizziness or fainting with exercise?				22 Shoulder or elbow injury?
		10 Fainting, bad headaches or convulsions?				23 Ankle pain or injury?
		11 Concussion or loss of consciousness?				24 Other serious Joint injury?
		12 Heat exhaustion, heatstroke or other problems with heat?				25 Broken bones (fractures)?
		13 Racing heart, skipped, irregular heartbeats, or heart murmur?		***YES***	***NO***	***Further history:***
		14 Seizures?				26 Birth defects (corrected or not)?
		15 Severe or repeated instances of muscle cramps?				27 Death of a parent or grandparent less than 40 years of age due to medical cause or condition?
Date of last known tetanus (lockjaw) shot:						28 Parent or grandparent requiring treatment for heart condition less than 50 years of age?
Date of last complete physical examination:						29 Been seen by a physician on an emergency or urgent basis in the last 12 months?

Explain all "YES" answers here along with any other facts or circumstances that should be disclosed prior to the examination (use reverse side of form):

PARENT/GUARDIAN'S AUTHORIZATION: I authorize a physician or duly authorized and supervised physician's assistant or nurse practitioner to perform a Sports Physical Evaluation on the student. The information set forth above is complete and accurate and I know of no reason why the student cannot fully and safely participate in the listed sports. I understand that this is solely a screening examination and that the absence of any health conditions or concerns listed below does not mean that student is free from actual or potential harmful health conditions that may cause the student injury or death while participating in sports. Any question or concern I may have regarding the student's health or safety will be referred to our personal physician or health care provider for review and evaluation.

PRINT PARENT/GUARDIAN NAME:	SIGNATURE OF PARENT/GUARDIAN:		
ADDRESS:	WORK #:	HOME #:	DATE:
REGULAR PHYSICIANS NAME:	OFFICE #:	PROVIDER/ORGANIZATION:	

PART 2 (TO BE COMPLETED BY THE EXAMINING PHYSICIAN/PHYSICIAN'S ASSISTANT/NURSE PRACTITIONER)

	NORMAL	ABNORMAL (Describe)	
EYES/EARS/NOSE/THROAT			HEIGHT:
SKIN			WEIGHT:
HEART			PULSE:
ABDOMEN			PULSE AFTER Ex:
GENITAL/HERNIA(MALES) MUSCULOSKETAL			BP:
A. NECK/SPINE/SHOULDERS/BACK			***RECOMMENDATION:***
B. ARMS/HANDS/FINGERS			☐ Unlimited participation
C. HIPS/THIGHS/KNEES/LEGS			☐ Limited participation/specific sports, events, activities
D. FEET/ANKLES			☐ Clearance withheld pending further testing/evaluation
NEUROLOGIC SCREENING EXAM (NSE)			☐ No athletic participation
			ONE OF THE ABOVE MUST BE CHECKED

COMMENTS (use reverse side of form):

PRINT NAME OF PHYSICIAN (M.D., D.O., P.A, OR N.P. ONLY)	PHYSICIAN'S SIGNATURE	DATE