

PART 2. PHYSICAL AND IMMUNIZATION HISTORY

**Please Note: Physical Exam must be performed and signed by a physician licensed in the State of California.*

Name: _____ Grade _____ Age _____ Date of Birth _____

Sport(s) _____ Sex: F _____ M _____

Height _____ Weight _____ Blood Pressure _____ Pulse _____ Respiration _____

Vision: Right _____ Left _____ Currently using corrective lenses? Yes _____ No _____

COMMENTS:

Binocularity: Normal: _____ Abnormal: _____

Dental Evaluation: Normal: _____ Abnormal: _____

Cardiovascular: Normal: _____ Abnormal: _____

Respiratory: Normal: _____ Abnormal: _____

Head/Neck Lymphatics: Normal: _____ Abnormal: _____

Ears/Nose/Throat: Normal: _____ Abnormal: _____

Gastrointestinal: Normal: _____ Abnormal: _____

Genital-Urinary: Normal: _____ Abnormal: _____

Musculo-Skeletal: Normal: _____ Abnormal: _____

Neurological: Normal: _____ Abnormal: _____

___ **WITHHELD FROM PARTICIPATION – PLEASE EXPLAIN:** _____

___ **LIMITED PARTICIPATION – PLEASE EXPLAIN:** _____

___ **CLEARED FOR UNLIMITED PARTICIPATION**

9TH GRADE AND TRANSFER STUDENTS NEED TO COMPLETE IMMUNIZATION QUESTIONS BELOW AND ATTACH A COPY OF IMMUNIZATION RECORDS:

Immunization Dates: Tdap(Pertussis Booster) Required _____ 2nd MMR _____

HEP B: #1 _____ #2 _____ #3 _____

Chicken Pox or Immunization Date _____

I, the undersigned, have given a thorough physical examination and reviewed the medical history of the candidate. I certify that all the important medical information has been included, and the information is complete and accurate.

***Physician's Signature** _____
(*Only CA licensed physician will be accepted)

Date _____

Physician's name (print) _____

Physician's Stamp:

Physician's address: _____

Physician's Phone # _____