

William S. Hart Union High School District
MEDICAL HISTORY
TO BE COMPLETED BY PARENT/GUARDIAN
BEFORE PHYSICIAN'S PHYSICAL EXAM

A medical history completed by the parents and a physician's verification that the student is healthy enough to participate in sport training and competition must be completed prior to the start of practice.

Name _____ Sex _____ Age _____ DOB ____/____/____

Grade _____ School _____ Sport _____

Please circle "Y" for yes, and "N" for no. (If yes, please explain)

1. Has the student-athlete had a medical illness or injury since his/her last check-up or sport physical? Y N

2. Is the student-athlete currently taking any prescription or non-prescription (over-the-counter) medication, or using an inhaler? Y N

3. Does the student-athlete have any allergies? (pollen, medicine, food, stinging insects, etc.) Y N

4. Has the student-athlete ever had a seizure? Y N

5. Has the student-athlete ever become ill from exercising in the heat? Y N

6. Have you ever passed out or nearly passed out during or after exercise? Y N

7. Have you ever had any discomfort, pain, tightness, or pressure in your chest during exercise? Y N

8. Does your heart ever race, flutter in your chest or skip beats (irregular beats) during exercise? Y N

9. Has a doctor ever told you that you have any heart problems? Y N

10. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. Y N

11. Do you get lightheaded or feel shorter of breath than your friends during an exercise? Y N

12. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (including drowning or unexplained car crash)? Unsure Y N

13. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? Unsure Y N

14. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? Unsure Y N

15. Is there any pertinent medical information that coaches or physicians should know about this student- athlete? Y N

16. Does the student-athlete wear glasses, contacts, or dental braces? Y N

Parent/Guardian's signature _____ Date _____

Physicals are valid for one year from the date of examination.

William S. Hart Union High School District
2025-26

CERTIFICATE OF PHYSICAL EXAMINATION

Must be completed by a Licensed (M.D., D.O., P.A. or NP)

*Due to new district guidelines, physicals can **no longer** be completed by a Chiropractor.*

Name _____ DOB ____/____/____

Height _____ Weight _____ Pulse _____ BP ____/____

Please put a “√” as either Normal or Abnormal for all findings below. Please describe, in detail, all abnormal findings.

	Normal	Abnormal	Comments
Heart			
Pulses			
Lungs			
Neck			
Back			
Shoulder/Arm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle/Foot			
Other pertinent medical findings			

Additional comments: _____

List any restrictions and duration: _____

I hereby certify that the above-named student was examined by me on _____ (date)
and found to be physically fit to engage in athletics.

Physician's signature _____

Stamp name or attach card of medical office here

