

Important!

All athletes must have a current physical screening on file in the Athletic Office prior to participation in any Sport

Sports Physicals \$50



OC Sports and Wellness
Will donate
\$25 back to
Trabuco Hills Athletics!



No appointment necessary – Walk-Ins Welcome!!

OC Sports and Wellness
26700 Towne Center Dr. Suite 100
Foothill Ranch, CA 92610

949.460.9111

Hours:

Monday through Friday 8am - 7pm
Saturday 9am - 3pm

Additional Sports Screening Physical Forms available @ Dr's office or
Download at www.trabucohills.org and click on "athletics"

Any minor not accompanied by a parent or guardian must have the below form signed

Consent / Patient Info

Name: _____ School: _____

Parent / Guardian Name: _____ Contact Phone Number: _____

Address: _____ City: _____ Zip: _____

I authorize OC Sports and Wellness Medical Group and its associates
to perform a sports physical on my child.

Parent / Guardian Signature

Date

TRABUCO HILLS HIGH SCHOOL SPORTS SCREENING ASSESSMENT

STUDENT'S NAME (PRINT): _____

DATE OF BIRTH _____ SEX: M F GRADE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

WEIGHT: _____ HEIGHT: _____

BLOOD PRESSURE: _____ / _____ PULSE: _____ RESP: _____

CIRCLE APPROPRIATE FINDINGS:

LUNGS: CLEAR WHEEZING RALES OTHER _____ PEAK FLOW _____

CARDIAC: RRRsM: MURMURS _____ /6: ARRHYTHMIAS OTHER _____

ABDOMEN: NORMAL (SOFT, BOWEL SOUNDS NL, NO MASSES) OTHER: _____

MUSCULOSKELETAL: CHECK ASYMMETRIC ROM, MUSCLE IMBALANCE, JOINT LAXITY, DEFORMITY,
PAIN/SWELLING

CIRCLE ANY JOINT WITH ABNORMAL FINDINGS AND ELABORATE:

NECK _____

SHOULDER _____

ELBOW _____

WRIST _____

HAND _____

BACK _____

HIPS _____

KNEES _____

ANKLES _____

FEET _____

EVALUATION (CIRCLE ONE)

1. UNLIMITED ATHLETIC PARTICIPATION

2. MAY PARTICIPATE PENDING FURTHER EVALUATION

Recommendation for further W/U _____

Referral to: _____

3. LIMITED ATHLETIC PARTICIPATION

Orthopedic limitations _____

4. ATHLETIC PARTICIPATION DENIED

Reasons _____

SIGNATURE OF EXAMINING/EVALUATING PHYSICIAN

DATE: (Mandatory) _____

**TRABUCO HILLS HIGH SCHOOL
SPORTS SCREENING HEALTH QUESTIONNAIRE**

STUDENT'S NAME _____

EMERGENCY CONTACT PERSON _____

RELATIONSHIP _____ **PHONE ()** _____

PRIMARY CARE PHYSICIAN _____

ADDRESS _____ **PHONE ()** _____

DATE OF LAST VISIT/PHYSICAL _____ **MEDICAL HISTORY:** It is important a parent or legal guardian fill out this form completely and accurately. It is an important part of providing health care to your child, and allows the physicians focus on important areas specific to your child.

Please circle all appropriate answers.

ALLERGIES? Y/N **DRUGS:** Penicillin Sulfa Other _____

ENVIRONMENTAL: Bee stings Pollen Dust Other _____

What happens during the allergic reaction? _____

Current Prescription medications? _____

Reason for medication _____

Bone, joint, tendon or ligament injuries requiring medical attention? Y/N

Explanation _____

Neck or back injuries/problems? Y/N

Explanation _____

Any previous surgery? Y/N

Explanation _____

Any previous hospitalizations? Y/N

Explanation _____

Any history of loss of consciousness? Y/N

If "Yes", was the athlete: knocked out fainted?

Any history of seizures? Y/N

Explanation _____

Wear glasses Contacts? Y/N

Any history of asthma? Y/N

If "Yes" is an inhaler required? Y/N

Has your child ever had any PE class limitations? Y/N

Explanation _____

Has student missed any of his/her immunizations? Y/N

Any uncorrected visual condition that may impair sports participation? Y/N

Does student have any medical problems listed below? Y/N

(Circle all appropriate answers)

Loss of an organ (i.e. kidney, spleen, eye, etc)

Bleeding problems (Anemia Sickle cell, hemophilia, etc)

Respiratory problems (i.e. Shortness of breath, asthma, tuberculosis, collapsed lungs, etc.)

Cardiac problems (i.e. Murmur, etc.)

Psychiatric problems requiring medical treatment

Leukemia

Menstrual problems

Any family history of: **(Circle all appropriate answers)**

Diabetes requiring insulin Bleeding problems

Heart problems Other _____

Is there any other medical condition that you know of that should be brought to the attention of the physicians or any reason why the athlete should be limited or withheld from athletic participation?

Y/N

Explanation _____

I hereby certify that the above information is true and correct.

Parent Signature _____ **Date** _____