Palisades Charter High School Male _____ Female _____

Sport Pre-participation Physical Examination and Health History School Year: _____

Last Name: _____ First: _____ MI___ DOB: _____ Grade: _____ Sport(s): _____

Address/City/Zip: _____ Parent Phone: _____

Health History (completed by student & parent prior to physical exam): explain „YES" answers; be specific, include approx. dates, current status

Heart Trouble	Yes	No	Asthma	Yes	No	Diabetes	Yes	No	Seizures	Yes	No
Palpitations	Yes	No	Fatigue	Yes	No	High Blood Pressure	Yes	No	Kidney conditions	Yes	No
Chest pain	Yes	No	Dizzy/fainting	Yes	No	Extreme shortness of breath/wheezing	Yes	No	Current skin condition	Yes	No
Family member w heart attack < 50 yrs of age, sudden death	Yes	No	Glasses, contacts, protective equipment, hearing aid	Yes	No	Head trauma, concussion, loss of consciousness	Yes	No	Family history of Marfan syndrome or sickle cell	Yes	No
Any allergies	Yes	No	Any injuries or fractures	Yes	No	Any surgeries or hospitalizations	Yes	No	Any other chronic condition	Yes	No

***Parent & student confirm that all of this information is correct and has been reviewed with the doctor during the examination. ***

List all medications for health conditions: _____

List all allergies(give reactions & meds) and/or asthma triggers: _____

Explain "YES" answers: _____

_____	_____	_____	_____
Student Signature	Date	Parent Signature	Date

PHYSICAL EXAMINATION and review of HEALTH HISTORY (completed by the physician)

Distance Vision: R 20/___ L 20/ ___ corrected: Y N		**HT: _____ WT: _____ BMI/% _____ BP: _____ Pulse: ____**	
	Normal		Normal
Appearance		Musculoskeletal	
Eyes/Ears/Nose/Throat		Neck	
Neck		Spine	
Cardiovascular		Shoulders/arms	
EKG results if done		Elbows/forearms	
Chest & Lungs		Wrist/hands	
Abdomen		Hips/thigh	
Skin		Knees	
Neuromuscular		Legs/ankles	
Genitalia – hernia (males)		Feet	

Diagnosed Chronic Conditions: _____

( ) Cleared - Full Activity ( ) Cleared – No management of chronic condition required during school or school sports

( ) Cleared - Chronic condition management required during school & school sports for _____Medication: *(use Pali med form)*

( ) Cleared with restrictions/end date: _____

( ) Cleared *after* proof of evaluation or rehab for: _____

( ) Not cleared/reason: _____

PHYSICIAN STAMP REQUIRED

Comments: _____

Physician Name_____ Physician's Original Signature: _____ Exam Date: _____

Palisades Charter High School

Request For Any OTC or RX Medication To Be Taken At School

PCHS Health Office (HO): 310 230-7218 Fax: 310 230-7246

I. Section To Be Completed By Parent:

_____/_____/_____/_____/_____

Student's Last Name First Name DOB School Year GR Sport(s)

- I understand I must provide any over-the-counter (OTC) or prescription (RX) medications as prescribed by doctor:
  - In its original container with proper labels; over-the-counter or prescription.
  - An updated doctor's order if there is a change in dosage, schedule or health status.
  - Student may not carry OTC or RX medications, except Health Office (HO) approved.
  - Parent must pick up unused medications by last day of school, if not; the medications will be disposed of properly.
- With doctor's orders and HO approval, my student may carry and self-administer without adult supervision but must follow MD orders. School Nurse must authorize any request to carry meds, i.e.: inhalers, epipen, insulin. I understand, accept there is no direct monitoring; student must alert staff for help. PCHS not responsible for any risk involved with improper use including: overuse, improper administration, breakage, theft, or loss. Health Office and/or Dean of Discipline will rescind consent if found to be sharing, playing or being careless with this medication.
  - Back-up meds in HO? Y / N . Health Office Approval to carry: _____
- **List All Triggers of:**
  Allergies SEVERE: _____

  Allergies MILD/MODERATE: _____

  List Triggers of Asthma: _____
- I consent to the PCHS School Nurse (or designee) communicating with the physician.
- I acknowledge that School Nurse (or designee) must authorize this order; student is given copy of orders when ok'd.

_____/_____/_____/_____

Print Parent Name Signature Date Phone(s) E-mail

II. Section To Be Completed By Physician:

Medication	Purpose/Diagnosis	Dosage	Time at School Or Frequency	End Date

Special instructions, side effects, recommending HO back-up supply? _____

Physician Stamp Required

__ May repeat rescue inhaler every 20 minutes times (___), call parent, then 911 if needed Yes__ No ___ I agree this student may carry inhaler, is capable and responsible.

_____ /_____ _____

Physician Printed Name/ Signature Date

This request expires at the end of the school year in which made. New doctor orders required each new school year.
See Administration of OTC & RX Medication in PCHS Parent/Student Handbook and applicable CEC.