PALMDALE SCHOOL DISTRICT

VOLUNTARY SPORTS ACTIVITIES PARTICIPATION FORM

ACKNOWLEDGMENT AND ASSUMPTION OF POTENTIAL RISK

I authorize my son/daughter, ______________________________ to participate in the after school sports activities of ____.

I understand and acknowledge that these activities, by their very nature, pose the potential risk of serious injury/illness to individuals who participate in such activities.

I understand and acknowledge that some of the injuries/illnesses which may result from participating in these activities include, but are not limited to, the following:

1.	Sprains/strains	5.	Paralysis
2.	Fractured bones	6.	Loss of eyesight
3.	Unconsciousness	7.	Communicable diseases
4.	Head and/or back injuries	8.	Death

I understand and acknowledge that participation in these activities is completely voluntary and as such is not required by the District for course credit or for completion of graduation requirements.

I understand and acknowledge that in order to participate in these activities, I and my son/daughter agree to assume liability and responsibility for any and all potential risks which may be associated with participation in such activities.

Transportation will be provided for the event(s) or activity(ies).

Palmdale School District, officers, employees, agents or volunteers may consent to emergency or other reasonable medical treatment of my son/daughter without further consent if my son/daughter becomes ill or injured, by preparing for, and/or is incident or related to, and/or as a result of participation in this voluntary activity, and the parent or guardian cannot be reached, unless the parent or guardian has previously filed with the school district a written objection to any medical treatment other than first aid.

I understand, acknowledge, and agree that the District, its employees, officers, agents, or volunteers shall not be liable for any injury/illness suffered by my son/daughter which is incident to and/or associated with preparing for and/or participating in this activity. I hereby waive, release, and discharge them from any future claims, demands, obligations, or causes of action for any injury/illness or property damage suffered by my son/daughter arising as a result of engaging or receiving instruction in said activity or any activity that is incidental thereto.

I acknowledge that I have carefully read this VOLUNTARY ACTIVITIES PARTICIPATION FORM and that I understand and agree to its terms.

______________________________________ ______________________

Parent/Guardian Date

______________________________________ ______________________

Student Signature Date

A signed VOLUNTARY ACTIVITIES PARTICIPATION FORM must be on file with the District before a student will be allowed to participate in the above extra-curricular activities.

DISTRITO ESCOLAR DE PALMDALE

FORMULARIO DE PARTICIPACION VOLUNTARIA EN ACTIVIDADES DEPORTIVAS AFIRMACION Y ASUNCION DE RIESGO

Autorizo a mi hijo/hija, ____________________________ para que participe en actividades deportivas después del horario regular de clases__________________________________.

Comprendo y afirmo que debido a la naturaleza de dichas actividades; éstas representan un riesgo potencial de daño/perjuicio a las personas que participan en ellas.

Comprendo y tengo entendido que algunas de estos daños/perjuicios que podría resultar por participar en estas actividades abarca pero no está limitado a lo siguiente:

1. Dislocado/luxado
2. Fracturas de huesos
3. Perdida de conocimiento
4. Lesiones en la cabeza y/o en la espalda
5. Parálisis
6. Pérdida de la vista
7. Enfermedades contagiosas
8. Muerte

Comprendo y afirmo que la participación en estas actividades es completamente voluntaria y como tal el distrito no está obligado a otorgar créditos para completar un curso o para graduarse.

Comprendo y afirmo que para poder participar en estas actividades, yo y mi hijo/a estamos de acuerdo en aceptar obligaciones y responsabilidades por cualquiera y todos los riesgos potenciales que puedan estar asociados con la participación en dichas actividades.

Transportación sera proveida durante el evento(s) o actividad(es).

El Distrito Escolar de Palmdale, administradores, empleados, agentes o voluntarios pueden dar su consentimiento para el tratamiento de emergencia u otro tratamiento médico razonable para mi hijo / hija sin otra autorización, si mi hijo / hija se enfermara o se lesionara, por la preparación, y / o incidente o relacionados con la , y / o como resultado de la participación en esta actividad voluntaria, y los padres o tutores no pueden ser contactados, a menos que el padre o tutor haya presentado anteriormente al distrito escolar una objeción por escrito a cualquier otro tratamiento médico aparte de primeros auxilios.

Comprendo, afirmo y estoy de acuerdo que el distrito escolar, sus empleados, administradores, representantes o voluntarios no son responsables de cualquier lesión/daño sufrida por mi hijo/hija; los cuales son resultado de y/o asociados con la preparación y/o participar en esta actividad.

Afirmo que he leído cuidadosamente este FORMULARIO DE PARTICIPACION VOLUNTARIA EN ACTIVIDADES y que comprendo y estoy de acuerdo con sus condiciones.

_____________________________________ ____________________

Padre/Madre o Tutor Legal Fecha

_____________________________________ ____________________

Firma del alumno/a Fecha

Deberá constar en los archivos del distrito escolar un FORMULARIO DE PARTICIPACION VOLUNTARIA EN ACTIVIDADES antes de permitir que el alumno/a participe en actividades extra-curriculares arriba mencionadas.

Palmdale School District
STUDENT ALTERNATE TRANSPORTATION FORM

Students participating in off-campus District-sponsored activities, including, but not limited to, practices, games, meetings, competitions, and conferences ("Events"), are required to travel on school buses or by other District-designated methods of transportation. Under special circumstances, with the District's prior written approval, Students may be transported to and from Events by: (1) the student's parent/guardian; (2) other designated adult;

Before the District grants a request for alternate transportation, the Student Alternate Transportation Form must be submitted to the School Office after the Student, the Student's parent / legal guardian, and the District employee supervising the Event have signed it. Parent/Guardians transporting only their child to and from activities will only need to fill out the Student Alternate Transportation Form. Before the Student Alternate Transportation Form will be accepted and approved by the School Office for other designated adults or for student drivers, these individuals must also complete and file with the School Office an acceptable (a) Personal Automobile Use Form (for parents/ guardians/designated adults) or (b) Student Personal Automobile Use Form (if the Student intends to drive himself/herself to Events).

If the required Forms are not submitted to and accepted by the School Office 48-hours before an Event, the Student must be transported to and from the Event through normal District-sponsored methods. A Student not complying with these provisions will not be allowed to attend or participate in the Event.

Name of Student:	
Event(s): Each approved Event or series of Events must be listed:	See Attached Athletic Schedule for Game Destinations
Date(s):	See Attached Athletic Schedule for Dates and Times
Reason for Request:	Transportation To and From 7th /8th Grade Athletic Events 2018 Season
Name of Designated Driver(s): Student and/or Designated Adult(s)	My child will be driven by one of the following: an approved Designated Driver / PSD Authorized Volunteer, or my child's parent/guardian.

In the event of an emergency, another district-approved designated driver, other than the driver(s) listed above, may transport your student to and from the district sponsored activity.

I/we agree that the designated drivers and vehicles to be used are not covered under the District's automobile liability coverage. The Student, his/her parent(s)/guardian(s), and/or the driver of the vehicle are solely responsible for damage or injury to others. I/we also agree that the Student and anyone else in the vehicle assume their own risk of harm, injury or death arising from this choice for alternate transportation. The Student, his/her parent(s)/legal guardian(s), and/or the vehicle driver further agree to hold the District and its officers, employees and volunteers free from any liability arising from this alternate transportation, agreeing also to defend and indemnify them against any resulting claim.

Printed Name of Student **Signature** **Date**

Printed Name of Parent/Guardian **Signature** **Date**

Printed Name of Supervising Employee **Signature** **Date**

Date Received by District:	**Received/Approved by:**

THIS FORM TO BE HELD ON FILE IN THE MAIN OFFICE FOR A PERIOD OF ONE (1) YEAR FROM THE DATE OF THE CURRENT SCHOOL YEAR

Palmdale School District Student Athletic Emergency Information Form

Parent Information: Please fill out completely and sign where indicated. In a major emergency, it is school district policy to retain students at school for their safety. This form will be used by the school staff when students are released to go home. Please complete electronically or print clearly and return completed form to school.

STUDENT'S LAST NAME		FIRST NAME	M.I.
BIRTH DATE	☐ MALE ☐ FEMALE	GRADE	HOME LANGUAGE

STUDENT'S HOME ADDRESS -- NUMBER	STREET	APT #	CITY	ZIP CODE
MAILING ADDRESS -- NUMBER (IF DIFFERENT FROM ABOVE)	STREET	APT #	CITY	ZIP CODE

PARENT'S / LEGAL GUARDIAN'S LAST NAME	FIRST NAME	RELATIONSHIP TO STUDENT	LIVES WITH? ☐ Yes ☐ No
WORK ADDRESS -- NUMBER	STREET	CITY	ZIP CODE

CONTACT NUMBERS		Indicate which phone to call for each message type:*				EMAIL ADDRESS:
HOME		EMERGENCY	☐ Home	☐ Cell	☐ Work	
CELL		ATTENDANCE	☐ Home	☐ Cell	☐ Work	
WORK		GENERAL INFO	☐ Home	☐ Cell	☐ Work	

PARENT'S / LEGAL GUARDIAN'S LAST NAME	FIRST NAME	RELATIONSHIP TO STUDENT	LIVES WITH? ☐ Yes ☐ No
WORK ADDRESS -- NUMBER	STREET	CITY	ZIP CODE

CONTACT NUMBERS		Indicate which phone to call for each message type:*				EMAIL ADDRESS:
HOME		EMERGENCY	☐ Home	☐ Cell	☐ Work	
CELL		ATTENDANCE	☐ Home	☐ Cell	☐ Work	
WORK		GENERAL INFO	☐ Home	☐ Cell	☐ Work	

To the principal: In case you are unable to reach me during any emergency, you are authorized to contact and, if necessary, release my child to any of the following:

NAME	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE
NAME	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE
NAME	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE

List any other family members attending this school:

LAST NAME	FIRST NAME	HOME ROOM	GRADE	RELATIONSHIP
LAST NAME	FIRST NAME	HOME ROOM	GRADE	RELATIONSHIP

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

The undersigned, as parent/legal guardian of, ______________________________ a minor,

(Print name of the student here)

hereby authorizes the principal or designee, into whose care the student has been entrusted, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care to be rendered to the student upon the advice of any licensed physician and/or dentist. It is understood that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the Palmdale School District ("District") to give specific consent to any and all such diagnosis, treatment, or hospital care which a licensed physician or dentist may deem necessary. This authorization is given in accordance with Section 49407 of the California Education Code, and shall remain effective until revoked in writing and delivered to the District. I understand that the District, its officers and its employees assume no liability of any nature in relation to the transportation of the student. I further understand that all costs of paramedic transportation, hospitalization, and any examination, X-ray, or treatment provided in relation to this authorization shall be my sole responsibility as the student's parent/guardian.

HEALTH ALERTS -- ***List any medical condition, which restricts physical activity or requires special attention. Include conditions such as asthma and allergies such as peanut and bee stings. If none, please indicate "none".***

DOES THE STUDENT HAVE HEALTH INSURANCE? (Check One) ☐ YES ☐ NO* If "Yes": ☐ Private Health Insurance ☐ Medi-Cal ☐ Healthy Families

MEDI-CAL / HEALTHY FAMILIES ID Number:

1. PRIVATE HEALTH INSURANCE NAME	GROUP NO.	2. PRIVATE HEALTH INSURANCE NAME (If covered under more than one plan)	GROUP NO.
NAME OF DOCTOR / MEDICAL OFFICE		PHONE NUMBER OF DOCTOR / MEDICAL OFFICE	

MY CHILD IS ALLERGIC TO THE FOLLOWING MEDICATIONS:	
MY CHILD CURRENTLY TAKES THE FOLLOWING MEDICATIONS:	

I CERTIFY THAT I HAVE READ AND UNDERSTOOD THIS FORM AND DO HEREBY GIVE MY AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT, AND THAT ALL OF THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE AND CORRECT.

X **DATE**

SIGNATURE OF: (CHECK ONE) ☐ PARENT ☐ LEGAL GUARDIAN

* Selected telephone number must be a direct dial number (no extensions).

STUDENT'S LAST NAME
FIRST NAME
MIDDLE INITIAL

Distrito Escolar de Palmdale
Formulario Atlético Estudiantil de Información Para Emergencias

Español

Información para Padres: ***Favor de llenar este formulario por completo y firmar en la sección indicada***. ***En caso de una emergencia grave las normas del distrito escolar requieren mantener a los alumnos en la escuela por su seguridad. El personal escolar usará este formulario cuando los alumnos sean permitidos volver a casa. Favor de llenar electrónicamente o con letra de molde clara y entregar el formulario completo en la escuela.***

APELLIDO DEL ALUMNO	NOMBRE	INICIAL

FECHA DE NACIMIENTO	☐ Masc. ☐ Femen.	GRADO	IDIOMA QUE SE HABLA EN CASA

DOMICILIO DEL ALUMNO – Número	CALLE	APT #	CIUDAD	CÓDIGO POSTAL
DOMICILIO POSTAL -- Número (SI DIFIERE AL DE ARRIBA)	CALLE	APT #	CIUDAD	CÓDIGO POSTAL

APELLIDO DEL PADRE/TUTOR LEGAL	NOMBRE	PARENTEZCO AL ALUMNO	VIVE CON EL ALUMNO ☐ Sí ☐ No
DIRECCIÓ N DEL TRABAJO / CALLE		CIUDAD	CÓDIGO POSTAL

Números telefónicos de contacto		Indicar a qué número llamar para cada tipo de mensaje:*				CORREO ELECTRÓNICO:
HOGAR		EMERGENCIA	☐ Hogar	☐ Celular	☐ Trabajo	
CELULAR		ASISTENCIA	☐ Hogar	☐ Celular	☐ Trabajo	
TRABAJO		INFORMACIÓN GENERAL	☐ Hogar	☐ Celular	☐ Trabajo	

APELLIDO DEL PADRE/TUTOR LEGAL	NOMBRE	PARENTEZCO AL ALUMNO	VIVE CON EL ALUMNO ☐ Sí ☐ No
DOMICILIO – número / CALLE		CIUDAD	CÓDIGO POSTAL

Números Telefónicos de Contacto		Indicar a qué número llamar para cada tipo de mensaje*				CORREO ELECTRÓNICO:
HOGAR		EMERGENCIA	☐ Hogar	☐ Celular	☐ Trabajo	
CELULAR		ASISTENCIA	☐ Hogar	☐ Celular	☐ Trabajo	
TRABAJO		INFORMACIÓN GENERAL	☐ Hogar	☐ Celular	☐ Trabajo	

Al director: En caso de no localizarme durante una emergencia, le autorizo a contactar y, de ser necesario, entregarle a mi niño a cualquiera de las siguientes personas:

NOMBRE	PARENTEZCO	TEL. DEL HOGAR	TEL. DE CELULAR	TEL. DEL TRABAJO
NOMBRE	PARENTEZCO	TEL. DEL HOGAR	TEL. DE CELULAR	TEL. DEL TRABAJO
NOMBRE	PARENTEZCO	TEL. DEL HOGAR	TEL. DE CELULAR	TEL. DEL TRABAJO

Incluir cualquier otro miembro de la familia que asista a esta escuela:

APELLIDO	NOMBRE	SALÓN PRINCIPAL	GRADO ESCOLAR	PARENTEZCO
APELLIDO	NOMBRE	SALÓN PRINCIPAL	GRADO ESCOLAR	PARENTEZCO

AUTORIZACIÓN PARA TRATAMIENTO MÉDICO DE EMERGENCIA

El abajo firmante, como padre/tutor legal de: ______________________________ menor de edad,

(Escribir el nombre del alumno con letra de molde)

por medio del presente autoriza al director o persona designada, habiéndosele encomendado el cuidado del alumno, a acceder a cualquier análisis con radiografía, anestesia, diagnóstico médico o quirúrgico, tratamiento y/o atención en hospital para el alumno, según lo especifique un médico acreditado y/o dentista. Estoy al tanto de que esta autorización se extiende antes de cualquier diagnóstico, tratamiento o atención en hospital necesaria y otorgo la autoridad y facultad al Distrito Escolar de Palmdale ("Distrito") de dar consentimiento a todo y cualquier diagnóstico, tratamiento, o atención en hospital con un médico acreditado o dentista conforme se determine necesario. Esta autorización se extiende de acuerdo con el Artículo 49407 del Código de Educación de California, y seguirá en vigencia hasta que se revoque por escrito y dicha revocación se entregue al Distrito. Entiendo que el Distrito, sus funcionarios y empleados no asumen responsabilidad de cualquier índole en relación con el transporte del alumno. También estoy al tanto de que el costo de transporte de paramédicos, hospitalización, análisis, radiografías, o tratamiento que se proporcione en relación con esta autorización será responsabilidad exclusivamente mía, como padre/tutor del alumno.

ALERTA DE SALUD – ***Incluir cualquier condición médica del alumno que limite actividad física o requiera atención especial. Incluir condiciones tales como asma y alergias (por ejemplo: a la crema de maní, o picaduras de abeja). Si el alumno no presenta ninguna condición indicar "ninguna".***

INDICAR SI EL ALUMNO TIENE SEGURO MÉDICO (Marcar uno)	☐ Sí	☐ No ,*	Si respondió "Sí" Indique:	☐ Seguro médico Particular	☐ Medi-Cal	☐ Healthy Families
# de miembro MEDI-CAL / HEALTHY FAMILIES:						

1. SEGURO MÉDICO PARTICULAR	GRUPO #	1. SEGURO MÉDICO PARTICULAR	GRUPO #
NOMBRE DEL DOCTOR/ CLÍNICA		NOMBRE DEL DOCTOR/ CLÍNICA	

MI HIJO ES ALÉRGICO A LOS SIGUIENTES MEDICAMENTOS: :	
MI HIJO ACTUALMENTE TOMA LOS SIGUIENTES MEDICAMENTOS:	

HAGO CONSTAR QUE LEÍ Y ENTIENDO ESTE FORMULARIO Y OTORGO MI AUTORIZACIÓN PARA TRATAMIENTO MÉDICO DE EMERGENCIA, Y QUE TODA LA INFORMACIÓN QUE PROPORCIONÉ EN ESTE FORMULARIO ES VERÍDICA Y CORRECTA.

X **FECHA**

FIRMA DE: (MARCAR UNO) ☐ PADRE ☐ TUTOR LEGAL

* El número telefónico seleccionado debe ser línea de marcado directo (no extensiones)

APELLIDO DEL ESTUDIANTE

NOMBRE

S.N.

Palmdale School District
Preparticipation Physical Evaluation History Form

Child's Name: ____ Sex: _____ Age: _____ Date of Birth: _______________
Grade: _____ School: ____________________________________ Sport(s): ____________________________________

This form should be filed in the patient's medical chart.

Medicines: Please list all prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:
____

Allergies: Do you have any allergies? ☐Yes ☐No If yes, please identify specific allergies below:
☐ Medicines: ________________________ ☐ Pollens: _____________________ ☐ Foods: _____________________ ☐ Stinging Insects: ____________

This section is to be carefully completed by the student and his/her parent(s) or legal guardian(s) before seeing the health care provider.
Explain Yes answers below. Circle questions that you don't know the answers to.

GENERAL QUESTIONS:	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections ☐ Other: ______________________________		
3. Have you ever spent the night in a hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU:	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐Kawasaki Disease ☐A Heart Infection ☐High Blood Pressure ☐A Heart Murmur ☐ High Cholesterol Other: ____________		
9. Has a doctor ever ordered a test for your heart (for example, ECG/EKG, echocardiogram)?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome?)		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament or tendon (for example, tear, sprain, or tendonitis) that caused you to miss a practice or game?		
18. Have you had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down Syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family that has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit of falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles, or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of food?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	**Yes**	**No**
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here:

I hereby state, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete: __________________________ Signature of parent/guardian: ________________________________ Date: ___________

Modified from "Preparticipation Physical Evaluation History Form" ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

Distrito Escolar de Palmdale
Evaluación física previa a la participación

Fecha del examen: ____________________

Nombre y apellido del estudiante: ________________________________ Sexo: _____ Edad: _____ Fecha de nacimiento: ______________

Grado: _____ Escuela: ____ Deporte(s): _________________________________

Dirección: ____ Teléfono: ________________________

Médico de cabecera/Proveedor de servicios médicos: ____

En caso de emergencia comunicarse con: Nombre y apellido: _________________________________ Relación: ________________________

Teléfono (Casa): __________________ (Trabajo): ______________ (Celular): ________________ (Celular): ______________________

Antecedentes

El estudiante y su padre, madre o tutor deberán llenar cuidadosamente esta sección antes de participar en atletismo interescolar.

		Sí	No
1.	¿Crees que gozas de buena salud?	☐	☐
2.	¿Tienes un problema de salud crónico (como diabetes o asma)?	☐	☐
3.	¿Estás tomando actualmente algún medicamento o pastillas, con o sin receta?	☐	☐
4.	¿Tienes alergia a los medicamentos, al polen, a los alimentos, o a las picaduras de insectos?	☐	☐
5.	¿Alguna vez algún doctor ha negado o ha restringido tu participación en deportes por cualquier motivo?	☐	☐
6.	¿Alguna vez te desmayaste o casi te desmayas MIENTRAS hacías ejercicio?	☐	☐
7.	¿Alguna vez te desmayaste o casi te desmayas DESPUÉS de hacer ejercicio?	☐	☐
8.	¿Alguna vez has sentido malestar, dolor o presión en el pecho al hacer ejercicio?	☐	☐
9.	¿Tu corazón se acelera o sientes que se detiene al hacer ejercicio?	☐	☐
10.	¿Te ha dicho el doctor alguna vez que tienes (marca con un círculo las que correspondan): Hipertensión / Soplo en el corazón / Colesterol Elevado / Infección en el corazón	☐	☐
11.	¿Alguna vez un doctor te ha ordenado un examen para el corazón (por ejemplo, electrocardiograma (ECG) o ecocardiograma)?	☐	☐
12.	¿Alguien de tu famlia ha fallecido sin ningún motivo aparente?	☐	☐
13.	¿Alguien de tu familia tiene enfermedad del corazón?	☐	☐
14.	¿Alguno de los miembros de tu familia o un pariente ha fallecido por problemas al corazón o ha fallecido súbitamente antes de los 50 años de edad?	☐	☐
15.	¿Alguien de tu familia tiene síndrome de Marfan?	☐	☐
16.	¿Alguna vez has pasado una noche en un hospital?	☐	☐
17.	¿Alguna vez te han operado?	☐	☐
18.	¿Alguna vez te has lesionado con un esguince, desgarro muscular o de ligamentos, o tendonitis, y tuviste que faltar a un entrenamiento o partido? Si contestas que sí, marca más abajo la zona afectada:	☐	☐
19.	¿Alguna vez te has quebrado o fracturado algún hueso o dislocado una articulación? Si contestas que sí, marca más abajo:	☐	☐
20.	¿Alguna vez has sufrido una lesión a los huesos o articulaciones que requirieran radiografía, imagen por resonancia magnética (MRI), tomografía computada (CT), operación, inyecciones, rehabilitación, terapia física, aparatos ortopédicos, yeso o muletas? Si contestas que sí, marca más	☐	☐

Cabeza Cuello Hombro Parte superior del brazo Codo Pecho Manos/Dedos Antebrazo

Tobillo Pie/Dedos de los pies Parte superior de la espalda Cintura Cadera Muslo Rodilla Pantorrilla/Espinilla

		Sí	No
21.	¿Alguna vez sufriste una fractura por sobrecarga?	☐	☐
22.	¿Alguna vez te han dicho que tienes o te has realizado una radiografía por inestabilidad atlantoaxial (cuello)?	☐	☐
23.	¿Usas regularmente un aparato ortopédico o un dispositivo auxiliar?	☐	☐
24.	¿Alguna vez te ha dicho algún doctor que tienes asma o alergia?	☐	☐
25.	¿Toses, resollas o respiras con dificultad durante o después del ejercicio?	☐	☐
26.	¿Hay alguien en tu familia que sufra de asma?	☐	☐
27.	¿Alguna vez usaste un inhalador o tomaste medicamento para el asma?	☐	☐
28.	¿Te falta o naciste sin un órgano, como uno de los riñones, un ojo, un testículo, u otro órgano?	☐	☐
29.	¿Has tenido mononucleosis infecciosa durante el último mes?	☐	☐
30.	¿Has tenido urticaria, escaras u otros problemas en la piel?	☐	☐
31.	¿Has tenido una infección epitelial (de la piel) por herpes?	☐	☐
32.	¿Alguna vez te has lesionado la cabeza o sufrido una conmoción cerebral?	☐	☐
33.	¿Alguna vez te han golpeado la cabeza y te sentiste confundido o perdiste la memoria?	☐	☐
34.	¿Alguna vez tuviste convulsiones?	☐	☐
35.	¿Tienes dolor de cabeza cuando haces ejercicio?	☐	☐
36.	¿Alguna vez has sentido entumecimiento, cosquilleos o debilidad en los brazos o las piernas después después de haber sido golpeado o de caer?	☐	☐
37.	¿Alguna vez no pudiste mover las manos o las piernas después de haber sido golpeado o de caer?	☐	☐
38.	Al hacer ejercicio en el calor, ¿sufres de fuertes calambres o te enfermas?	☐	☐
39.	¿Algún doctor te ha dicho alguna vez que tú o alguien de tu familia sufren de anemia drepanocítica o anemia de células falciformes?	☐	☐
40.	¿Alguna vez tuviste problemas con los ojos o la vista?	☐	☐
41.	¿Usas anteojos o lentes de contacto?	☐	☐
42.	¿Usas anteojos protectores, como gafas o máscaras protectoras?	☐	☐
43.	¿Estás contento(a) con tu peso?	☐	☐
44.	¿Estás tratando de engordar o adelgazar?	☐	☐
45.	¿Alguien te ha recomendado que modifiques tu peso o tus hábitos alimenticios?	☐	☐
46.	¿Te limitas o controlas con cuidado lo que comes?	☐	☐
47.	¿Tienes alguna inquietud que desearas discutir con un doctor?	☐	☐

SÓLO PARA MUJERES

		Sí	No
48.	¿Alguna vez has tenido un periodo menstrual?	☐	☐
49.	¿Cuántos años tenías cuando tuviste tu primer periodo menstrual?	______	
50.	¿Cuántos periodos has tenido en los últimos 12 meses?	______	

Explica aquí tus respuestas "Sí": (Agrega hojas adicionales si es necesario)

Yo por la presente declaro que, según mi leal saber y entender, mis respuestas a las preguntas anteriores son correctas y están completas.

Firma: ____ (Atleta)

Firma: ___________________________________ (Padre, madre o tutor)

Fecha: ___________

Palmdale School District
Physical Examination Form for Preparticipation

The section below is to be completed by physician or provider after history and consent forms are completed.

Student's Name: ______________________________ DOB: ______________

Height: ________ Weight: ________ %BMI (optional): _________ Pulse: ________ BP: ______/ _______, (_______/_______, ________/_______)

Vision R 20/ _________ L 20/ __________ Corrected: Y N Pupils: Equal Unequal

EMERGENCY INFORMATION

Allergies: ______________________________

Other Information: ______________________________

MEDICAL	Normal	Abnormal Findings
Appearance ● Marfan stigmata (kyphoscoliosis, high arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ Ears/ Nose/ Throat ● Pupils equal ● Hearing		
Lymph Nodes		
Heart [1] ● Murmurs (auscultation standing, supine, +/- Valsalva) ● Location of point of maximal impulse (PMI)		
Pulses ● Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) [2]		
Skin ● HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [3]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/ Arm		
Elbow/ Forearm		
Wrist/ Hand/ Fingers		
Hip/ Thigh		
Knee		
Leg/ Ankle		
Foot/ Toes		
Functional ● Duck-walk, single leg hop		

[1] Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

[2] Consider GU exam if in private setting. Having third party present is recommended.

[3] Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

Clearance

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for: ______________________________

☐ Not cleared:

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports: ______________________________

Reason/Recommendations: ______________________________

I have evaluated the above named student and completed the preparticipation physical evaluation. The athlete does not present apparent contraindications to practice, tryout, and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parent. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Physician/ Provider: (print/ type/ stamp) ______________________________(MD, DO, NP, or PA) Date: ____________

Address: ______________________________ Phone: ____________________

Signature of Physician/ Provider: ______________________________

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