Attention Parents/Guardians and Athletes:

All Athletic Physicals are valid for ONE (1) year.

- A Ticket to Play/Athletic packet must be completed and turned in before you try out for any sport by the pre-designated date. **(Please print pages separately, do not turn in front-to-back.)** This will help expedite the process.

- If you came to RBHS physical night in the Spring, your physical is good for the entire next school year; you do not need another physical/ticket to play for each sport season.
  Ex: If you came to Physical Night in June 2019, your physical is good throughout the entire 2019-20 school year. If you had your physical in April 2019, your physical is good only for the 2019-20 Fall and Winter sports seasons.

- If your physical will expire in the middle of the season, you must have a new physical done before tryouts. Please turn in the physical form to the Athletic department.

- If you are a new student (new to RBHS/PUSD), you can get your physical from your old school and turn it in (as long as it’s not expired) but you must fill out the other RBHS Ticket to Play paperwork. If your physical from the old school is expired or will expire during the sport season, you will need a new physical before tryouts.

If you’re not sure whether you already had a physical or have other questions, please ask!
(858) 485-4800 ext. 4508
Athletic Director: Peggy Brose pbrose@powayusd.com
Athletic Trainer: Robbie Bowers, ATC rbowers@powayusd.com

The Poway Unified School District (PUSD) is an equal opportunity employer/program and is committed to an active Nondiscrimination Program. PUSD prohibits discrimination, harassment, intimidation, and bullying on the basis of actual or perceived race, color, ancestry, national origin, nationality, immigration status, ethnicity, ethnic group identification, age, religion, marital or parental status, physical or mental disability, sex, sexual orientation, gender, gender identity, or gender expression or association with a person or group with one or more of these actual or perceived characteristics. For more information, please contact the Title IX/Equity Compliance Officer,
Associate Superintendent of Personnel Supportive Services,
Poway Unified School District, 15250 Avenue of Science, San Diego, CA 92128-3406, 858-521-2800, extension 2761
Parent/Athlete Copy
DO NOT TURN IN THIS PAGE
**POWAY UNIFIED SCHOOL DISTRICT**

**Athletic Screening History & Physical Exam**

<table>
<thead>
<tr>
<th><strong>Student Name</strong> <em>(Print Clearly):</em></th>
<th><strong>Date of Birth:</strong></th>
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<td>First:</td>
<td>Last:</td>
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<tr>
<th><strong>Address:</strong></th>
<th><strong>Graduating Year:</strong></th>
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<tr>
<th><strong>Home Phone:</strong></th>
<th><strong>Father’s Work Phone:</strong></th>
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<tr>
<th><strong>Mother’s Work Phone:</strong></th>
<th><strong>Emergency Contact/Phone:</strong></th>
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**EXPLANATION OF SCREENING PHYSICAL**

I realize that the medical evaluations performed are only screens in order to evaluate general health, to disclose existing problems, and to determine my son/daughter’s dynamic ability to participate in a given sport so that obvious conditions which might be damaged or aggravated by competitive sports can be found, evaluated and treated so as to prevent further injury. This examination does not guarantee against injury.

**Parent Initials** ____________

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**AWARENESS OF RISK**

STUDENT AND PARENT – I am aware that playing/practicing sports can be a dangerous activity involving many risks of injury. I understand that the risks of participation include, but are not limited to, death, serious neck and spinal cord injuries that may result in complete or partial paralysis, brain damage, serious internal injury to virtually any internal organs, bones, joints, muscles, tendons, or any other aspect of the skeletal system, and serious injury or impairment to other aspects of my body, general health and well being. I understand that the risks of participation may result not only in serious injury, but in impairment of my future ability to earn a living, to engage in other business, social and recreational activities, and generally to enjoy a good life. Because of the dangers of participating in sports, I recognize the importance of following coaches’ instructions regarding playing techniques, training, equipment and other team rules, etc. both in competition and practice and agree to obey such instructions.

**Parent Initials** ____________

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**PERMISSION FOR TREATMENT**

I hereby grant permission to the team physicians and those professional personnel designated by Poway Unified School District to treat my son/daughter in the event of an injury. In the event of a serious injury, if I am unable to give my consent at the time, this consent is to include any and all emergency procedures deemed necessary by the attending emergency personnel. I also understand that in the event of injury, every reasonable attempt will be made to contact me prior to securing medical treatment beyond basic first-aid.

**Parent Initials** ____________

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**PROOF OF INSURANCE**

In compliance with California Education Code 32221, I certify that there is in effect at this time insurance coverage for medical expenses resulting from bodily injury of at least $5,000 for my son/daughter, and that this coverage will remain in effect throughout the time that he/she participates in sports. I also give my permission for the above named student to participate in sports, including regularly scheduled trips by supervised school transportation.

**Parent Initials** ____________

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<table>
<thead>
<tr>
<th><strong>Insurance Carrier</strong></th>
<th><strong>Policy #</strong></th>
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I have read the above statements, EXPLANATION OF SCREENING PHYSICAL, AWARENESS OF RISK, and PERMISSION FOR TREATMENT, and understand them fully and agree/consent to their contents.

**Parent Signature** X ___________________________ **Date** ____________

**Student Signature** X ___________________________ **Date** ____________
Health History - Please answer the following in the check box provided. Explain “yes” answers in the box below.

1. Have you ever been hospitalized (overnight)? [ ] Yes [ ] No
   Have you ever had surgery? [ ] Yes [ ] No

2. Are you currently taking medication? [ ] Yes [ ] No

3. Do you have any allergies (medicines, pollen, bees)? [ ] Yes [ ] No

4. Have you ever passed out during exercise? (not from heat) [ ] Yes [ ] No
   Have you ever had surgery? [ ] Yes [ ] No
   Do you tire more quickly than your friends during exercise? [ ] Yes [ ] No
   Have you ever had high blood pressure? [ ] Yes [ ] No
   Have you ever been told you had a heart murmur? [ ] Yes [ ] No
   Have you ever had racing of your heart or skipped beats? [ ] Yes [ ] No
   Has anyone in your family died of heart problems or a sudden death before age 40? [ ] Yes [ ] No

5. Do you have any skin problems (itching, rashes, breaking out)? [ ] Yes [ ] No

6. Have you ever had a head injury? [ ] Yes [ ] No
   Have you ever been knocked out? [ ] Yes [ ] No
   Have you ever had a seizure? [ ] Yes [ ] No
   Have you ever had a burner/stinger? (pain from neck to arm) [ ] Yes [ ] No

7. Have you ever had heat cramps? [ ] Yes [ ] No
   Have you ever been dizzy or passed out in the heat? [ ] Yes [ ] No

8. Do you use special pads or braces? [ ] Yes [ ] No

9. Have you ever injured (broken/fractured, sprained, dislocated):
   [ ] Hand/fingers  [ ] Shoulder  [ ] Hip  [ ] Shin/calf
   [ ] Wrist/forearm  [ ] Neck  [ ] Thigh  [ ] Ankle
   [ ] Elbow  [ ] Chest/ribs  [ ] Knee  [ ] Foot/toes
   [ ] Upper arm  [ ] Back  [ ] Stress fractures? ___________________

10. Have you ever had:
    [ ] Mononucleosis  [ ] Diabetes  [ ] Measles  [ ] Hernia(s)
    [ ] Hepatitis  [ ] Headaches (frequent)  [ ] Asthma  [ ] Ulcers
    [ ] Eye/ear injuries  [ ] Tuberculosis  [ ] Sickle cell trait/disease

11. When was your last tetanus shot? ___________________

12. About your weight: Do you think you are… [ ] just right? [ ] too heavy? [ ] too light/thin?
    Do you like to drink dairy (milk) products? [ ] Yes [ ] No
    For females:
    When was your first period and how old were you? ___________________
    When was your last period? ___________________
    Are your periods [ ] Regular/monthly? [ ] Irregular/skip months?

13. Please ask the doctor to address any questions that you may have. [All discussions are kept confidential.]

Please explain any “yes” answers here:
Circle the sports you are interested in:

- Baseball
- Cross Country
- Golf
- Roller Hockey
- Swim/Dive
- Volleyball
- Other

- Basketball
- Field Hockey
- Gymnastics
- Soccer
- Track/Field
- Water Polo
- Cheerleading
- Football
- Lacrosse
- Softball
- Tennis
- Wrestling

**PRE-PARTICIPATION PHYSICAL EVALUATION**

(This form is to be completed by the physician. Submit original to RBHS Athletics Office.)

Student Name *(Print Clearly)*:

First: 

Last: 

Date of Birth: 

Current Age: 

**EXAMINATION**

Height: 

Weight: 

BP: / 

(Putting, left arm)

Pulse: 

Body Fat % (optional): 

Vision: R 20/ 

L 20/ 

Corrected  Yes  No

**MEDICAL**

Appearance (to include general congenital/development deformities)

Eyes/Ears/Nose/Throat (pupils equal, hearing)

Lymph Nodes

Heart (murmurs, location of point of maximal impulse)

Pulses (simultaneous femoral and radial pulses)

Lungs

Abdomen

Genitourinary (males only, to include hemia) - Optional

Skin (HSV, lesions suggestive of MRSA, Linea corporis)

Neurologic (including reflexes)

**MUSCULOSKELETAL / ORTHOPEDIC**

Cervical Spine

Back (thoracic/lumbar)

Shoulder/arm

Elbow/Forearm

Wrist/Hand/Fingers

Hip/Thigh

Knee

Leg/Ankle

Foot/Toes

Functional (duck-walk, single leg hop, front squat)

Tanner Staging 1 – 5 - Optional

Patient Education Provided:

- Stretching emphasized
- Discussed prevention of sun/heat-related problems
- Discussed fitness/ideal weight
- Discussed treatment of acute injuries
- Discussed testicular cancer exams
- Vaccination record review

- CLEARED for all sports WITHOUT restriction.  Cleared for all sports without restriction with recommendations outlined above in findings/recommendations
- NOT CLEARED:  Pending further evaluation  For any sports  For certain sport __________________________

Needs clearance by specialist:  Orthopedist  Cardiologist  Other __________________________

Explain ____________________________________________________________________________________________

________________________________________________________________________________________

**Physician’s Statement:**

Student’s Name *(Print Clearly)* was examined by me on *(date)* for a pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. 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.

Physician’s Signature: X __________________________

Do not sign without student’s name filled in  Date 

**Text Box:**

- PHYSICIAN'S STAMP HERE
POWAY UNIFIED SCHOOL DISTRICT  
MEDICAL INFORMATION RELEASE FORM FOR CO-CURRICULAR ACTIVITY

This form is provided to the coach and will be taken with the team wherever they travel. Please fill it out completely and be specific. The form gives parental consent for any staff/chaperone approved by the school principal to secure emergency services (medical, dental, paramedic, ambulance) for the student at the parent/guardian expense. Efforts will be made to contact the parent/guardian prior to treatment or hospitalization. An authorization with a physician's signature must be attached if the athlete takes any prescription medication.

<table>
<thead>
<tr>
<th>Student Name (Print Clearly)</th>
<th>Sport(s)- Check all that apply</th>
<th>Sport(s) Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>First:</td>
<td>Fall</td>
<td></td>
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<tr>
<td>Last:</td>
<td>Winter</td>
<td></td>
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<tr>
<td>State</td>
<td>Spring</td>
<td></td>
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</tbody>
</table>

Parent/Guardian Name:  
Graduating Year:  
Fall Grade (circle one): 9 10 11 12

<table>
<thead>
<tr>
<th>Address:</th>
<th>City:</th>
<th>Zip:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Phone:</td>
<td></td>
<td></td>
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<tr>
<td>Mother Cell:</td>
<td>Father Cell:</td>
<td>Father Work:</td>
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</table>

IN CASE OF EMERGENCY, A REPRESENTATIVE OF THE PUSD ATHLETIC DEPARTMENT HAS THE AUTHORITY TO SECURE MEDICAL OR SURGICAL TREATMENT AND TRANSPORT AS NECESSARY. EVERY ATTEMPT WILL BE MADE TO CONTACT THE EMERGENCY PERSONS LISTED BELOW.

<table>
<thead>
<tr>
<th>Family Doctor:</th>
<th>Dr. Phone #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Contact 1 Name:</td>
<td>Emergency Contact 2 Name:</td>
</tr>
<tr>
<td>First:</td>
<td>Last:</td>
</tr>
<tr>
<td>Relationship to Student:</td>
<td>Relationship to Student:</td>
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<tr>
<td>Phone #:</td>
<td>Phone #:</td>
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</tbody>
</table>

List all information helpful to a physician in case of emergency including information which school staff and chaperones need to be aware of regarding the student's safety. Updated information shall be provided by the parent/guardian.

| MEDICAL PROBLEMS:         | TREATMENT:          |
| (diabetes, asthma, seizures) |                       |

| ALLERGIES:             | TREATMENT:          |
| (food, bee stings, medication) |                       |

SCHOOL RULES ARE IN EFFECT FOR ALL SCHOOL SPONSORED ACTIVITIES

MEDICATION: Prescription and non-prescription medications are permitted only with a written statement from the physician and parent/guardian indicating desire that the District assist the student as set forth by the physician. If prescription or non-prescription medication is necessary, an AUTHORIZATION FOR MEDICATION ADMINISTRATION must be attached. I understand that staff/chaperones may assist my student in taking the medicine(s) as directed by my physician. I will provide the medicine(s) in the prescription container(s) labeled with the name of my student, the prescribing physician’s name, and the time and dosage of medication prescribed. I agree to hold harmless and indemnify the Poway Unified School District, its officers, employees, agents or chaperones from and against any and all liability, loss, expense or claims for illness, injury or damage any student may incur from medication assistance.

I UNDERSTAND THAT BY SIGNING THIS FORM:
1. I give permission for my son or daughter to participate in Poway Unified School District athletics.
2. I give permission for staff/chaperones to provide first aid care and secure emergency care at my expense if needed.
3. I release the Poway Unified School District, its officers, employees, agents and its chaperones from any and all liability, loss, expense or claim for illness, injury or damages that may arise from participation in the athletics program or any associated activity. Further, I understand that the District does not provide accident/medical insurance for students and that I am expected to provide such insurance coverage.
4. I am aware that injuries may occur to the athlete while participating in interscholastic athletics. I have been advised of this danger.

---

NAME OF INSURANCE COMPANY: __________________________        INSURANCE POLICY/GROUP NUMBER: __________________________

PARENT/GUARDIAN SIGNATURE: __________________________    DATE: __________________________    PRINTED NAME OF PARENT/GUARDIAN: __________________________
1. I am the one with whom this student-athlete **resides**: (check one box):
   - Parent
   - Legal Guardian
   - Relative
   - Caretaker
   - Foster Parent
   - Emancipated Minor

2. Is this the same residence this athlete had last year?  □ Yes  □ No  Previous Address:

3. Student Status: □ Continuing Student  □ Incoming 9th Grader  □ New Resident  □ Administrative Placement  □ Intra-District Transfer  □ Inter-District Transfer

4. School attended last year if athlete is **new and came from another high school**:

   Name of School  Address  City/State/Zip

   Sports played at previous school and level of play (varsity, JV, freshman)
   a. Did anyone influence this student to come to this school?  □ Yes (explain)  □ No
   b. Has there been contact with anyone from this school within the past 24 months?  □ Yes (explain)  □ No
   c. Did he/she move with the same family members, caregivers or legal guardians?  □ Yes  □ No
   d. Did discipline issues require the athlete to leave his/her former school?  □ Yes  □ No

5. I verify that this street address is within the High School boundaries and/or I have followed the District transfer procedures. I also understand that falsifying this information may cause immediate ineligibility for two years and team forfeiture.

   Print Name of Person Checked on Line 1  
   Signature of Person with Whom Student/Athlete Resides  Date  Student/Athlete Signature  Date

   -----------------------------------------------
   **ATHLETIC HANDBOOK:** I have reviewed and agree to abide by the guidelines/policies in the Athletic Handbook which is posted on the school website. I acknowledge that it is my responsibility to read and understand these rules and discuss them with my parent/guardian/athlete.

   Parent Initials  Student Initials

   **CIF CONCUSSION INFORMATION:** I agree that the safety of the athletes always come first. I have read the CIF Concussion Information Sheet posted on the school website and am familiar with the signs and symptoms of a concussion. I understand and support the decision that any athlete suspected of suffering a serious head injury may be removed from a game or practice immediately and will not be allowed to return to activity until medically cleared.

   Parent Initials  Student Initials

   **CIF SUDDEN CARDIAC ARREST INFORMATION:** I have reviewed the SCA Information Sheet posted on the school website and understand the symptoms and warning signs of SDA and the CIF protocol to incorporate SCA prevention strategies into my students' sports program. I understand & support the decision that any athlete displaying signs or symptoms associated with SCA may not return to play until medically cleared.

   Parent Initials  Student Initials

   **CIF OPIOID INFORMATION:** I have reviewed the Opioid Information Sheet posted on the school website and understand the risks and side effects of opioid use. I am aware I should talk to my health care provider about other options to manage pain and ways to help prevent the misuse/abuse of opioids should they be legally prescribed for pain.

   Parent Initials  Student Initials

   **ATHLETIC POLICY AGAINST HAZING:** I understand that hazing of any kind is not allowed on this campus and in the athletic program. This includes mental, verbal and physical acts. I further understand that it is my duty to report any acts of hazing that I see to a coach or administrator on campus. I agree to uphold this District policy and understand that any violation will result in my immediate suspension from athletics and further disciplinary action as outlined in District policy and procedures.

   Parent Initials  Student Initials

   **ETHICS IN SPORTS POLICY:** I accept & understand the Policy Statement, Code of Ethics, The Pillars & Principles of Pursuing Victory With Honor, & the Violations, Minimum Penalties, and Appeal Process of the CIF- San Diego Section ETHICS IN SPORTS Policy posted on the cifds.org website. I agree to abide by this policy while participating and/or spectating at CIFSDS athletic events regardless of contest site or jurisdiction.

   Parent Initials  Student Initials

   **MEDIA RELEASE:** I understand my name, picture, and/or grade point average may be released to the media. I agree to abide by this policy while participating and/or spectating at CIFSDS athletic events regardless of contest site or jurisdiction.

   Parent Initials  Student Initials

I have read all of the above statements and understand them fully and agree/consent to their contents.

   Parent/Guardian Signature  Date  Student/Athlete Signature  Date