

**St. Joseph High School**  
4120 S. Bradley Road, Santa Maria, CA 93455  
805-937-2038

**2025-26**

**PHYSICAL FORM**

**HISTORY FORM--PG 1 of 2**

**Student's Name:** \_\_\_\_\_ **Sex:** M / F **Age:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **(2025-26) Grade:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Sport (s):** \_\_\_\_\_

**Parents, please fill out prior to physical. Explain "Yes" answers below. Circle questions you don't know the answer to.**

	Yes	No		Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reasons.	___	___	24. Do you cough, wheeze or have difficulty breathing during or after exercise?	___	___
2. Do you have an ongoing medical condition?	___	___	25. Anyone in your family who has asthma?	___	___
3. Are you currently taking any medicines?	___	___	26. Ever used an inhaler or taken asthma med?	___	___
4. Do you have allergies to medicine, foods etc?	___	___	27. Were you born w/o or missing a kidney, eye, testicle or any other organ?	___	___
5. Have you ever passed out or nearly passed out DURING exercise?	___	___	28. Ever had infectious mononucleosis within the last month?	___	___
6. Have you ever passed out or nearly passed out AFTER exercise?	___	___	29. Ever had rashes, pressure sores or other skin problems?	___	___
7. Have you ever had discomfort, pain or pressure in your chest during exercise?	___	___	30. Ever had a herpes skin infection?	___	___
8. Does your heart race or skip beats during exercise?	___	___	31. Ever had a head injury or concussion?	___	___
9. Has a doctor ever told you that you have: ___ High blood pressure ___ A heart murmur ___ High cholesterol ___ A heart infection	___	___	32. Been hit in head & been confused or lost memory?	___	___
10. Has a doctor ever ordered a test for your heart?	___	___	33. Ever had a seizure?	___	___
11. Anyone in your family died for no apparent reason?	___	___	34. Do you have headaches with exercise?	___	___
12. Anyone in your family have a heart problem?	___	___	35. Ever had numbness, tingling or weakness in your arms or legs after being hit or falling?	___	___
13. Has any family member or relative died of heart problems or sudden death before age 50?	___	___	36. Ever been unable to move your arms or legs after being hit or falling?	___	___
14. Anyone in your family have Marfan syndrome?	___	___	37. When exercising in the heat, do you have severe muscle cramps or become ill?	___	___
15. Ever spent the night in a hospital?	___	___	38. Has a doctor ever told you that you or someone in your family has sickle cell trait/disease?	___	___
16. Ever had surgery?	___	___	39. Have any problems with your eyes or vision?	___	___
17. Ever had an injury like a sprain, muscle or ligament tear or tendonitis that caused you to miss practice/game? If yes, circle affected area below:	___	___	40. Do you wear glasses or contacts?	___	___
18. Ever had any broken/fractured bones or dislocated joints? If yes, circle below:	___	___	41. Do you wear protective eyewear?	___	___
19. Ever had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehab, physical therapy, a brace, cast or crutches? If yes, circle below.	___	___	42. Are you happy with your weight?	___	___
<div style="display: flex; flex-wrap: wrap;"><div style="width: 33%;">Head</div><div style="width: 33%;">Neck</div><div style="width: 33%;">Shoulder</div><div style="width: 33%;">Upper arm</div><div style="width: 33%;">Elbow</div><div style="width: 33%;">Forearm</div><div style="width: 33%;">Hand/fingers</div><div style="width: 33%;">Chest</div><div style="width: 33%;">Back</div><div style="width: 33%;">Hip</div><div style="width: 33%;">Thigh</div><div style="width: 33%;">Knee</div><div style="width: 33%;">Calf/shin</div><div style="width: 33%;">Ankle</div><div style="width: 33%;">Foot/toes</div></div>					
20. Ever had a stress fracture?	___	___	43. Are you trying to gain/lose weight?	___	___
21. Ever been told that you have or had an x-ray for Atlantoaxial (neck) instability?	___	___	44. Has anyone recommended you change your weight or eating habits?	___	___
22. Do you regularly use a brace or assistive device?	___	___	45. Do you limit or carefully control what you eat?	___	___
23. Do you have asthma or allergies?	___	___	46. Do you have any concerns that you would like to discuss with a doctor?	___	___

**FEMALES ONLY**

47. Have you ever had a menstrual period? \_\_\_ \_\_\_

48. How old were you when you had your first menstrual period? \_\_\_ \_\_\_

49. How many periods in the last 12 months? \_\_\_ \_\_\_

Explain "Yes" answers here: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PARENT PERMISSION FOR STUDENT TO PARTICIPATE IN ATHLETIC COMPETITION AND FOR THE PHYSICAL TO BE PERFORMED.**

I hereby give consent for my child to receive a physical exam from a doctor for the purpose of completing in athletics at St. Joseph High School and also state, that to the best of my knowledge, my answers to the above questions are complete and correct. I hereby give my consent for my son/daughter to compete in athletic competition. In case this student is injured, the coaches are authorized to have him/her treated. I also understand and agree to adhere to the SJHS provisions in the Athletic Department Handbook.

**This form must be returned to the Athletic Department prior to any practice and or play.**

\_\_\_\_\_  
**Parent / Guardian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Athlete's Signature**

# PHYSICAL FORM 2025-26

# EXAMINATION FORM—PG 2

Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_ BP: \_\_\_\_\_

Medical	Normal	Abnormal	Initials
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin			
<b>Musculoskeletal</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

☐ CLEARED TO PLAY SPORTS      ☐ **NOT CLEARED TO PLAY SPORTS**      Comments: \_\_\_\_\_

Name of Physician (**Please print / type**): \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**“This is for athletic participation only and is not intended to be a comprehensive medical evaluation. Certain conditions may exist which may not be identified by this screening. Your personal doctor should be contacted for comprehensive evaluation and screening.”**

Student Athletes need a current physical each school year to participate in athletics & cheer.

## Consent for Emergency Treatment in Advance

Please print all information

Athlete's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

Allergies: \_\_\_\_\_ Medications: \_\_\_\_\_

Personal Doctor: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_ Ext. \_\_\_\_\_

Father's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_ Ext. \_\_\_\_\_

Other Emergency Contact, Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

“We, the parents/guardians of the above named athlete, do hereby consent to any and all emergency medical, hospital and surgical care that may be necessary by a physician, without obtaining further consent provided that the hospital is unable to reach us at the phone numbers listed above.