Sweetwater Union High School District

1130 Fifth Avenue, Chula Vista CA 91911 619-585-6015

Parent Consent

STUDENT NAME: _____ SCHOOL: _____

I hereby give my consent for my son/daughter _____ to be given a Sport/Co-curricular Participation Screening Examination and (if indicated an EKG/ECHO CARDIOGRAM) by a team of Sports Medicine Specialists (Orthopedic Surgeon, Family Practitioner, Certified Athletic Trainers and Physical Therapist).

_____ _____

Date *Signature of Parent/Guardian*

PHYSICAL EXAM

Height:	_____		Weight:	_____
Blood Pressure:	_____		Pulse:	_____
Vision (R):	_____		Vision (L):	_____
Flexibility/Posture:	Normal	Abnormal		
Upper Extremities	_____	_____		
RON Screens:				
Lower Extremities	_____	_____		
Scoliosis	NO	YES		

Comments: _____

ORTHOPEDIC EXAMINATION

Upper Extremities	Normal	Abnormal	Lower Extremities	Normal	Abnormal
Shoulder	_____	_____	Hip	_____	_____
Elbow	_____	_____	Knee	_____	_____
Wrist/Hand	_____	_____	Ankle	_____	_____
Spine	_____	_____	Foot	_____	_____

Comments: _____

PHYSICAL EXAMINATION

	Normal	Abnormal		Normal	Abnormal
Head & Neck	_____	_____	Cardiovascular	_____	_____
Eyes	_____	_____	Gastrointestinal	_____	_____
Ears/Nose & Throat	_____	_____	Genito-Urinary	_____	_____

Comments: _____

PHYSICIAN DETERMINATION

In my opinion this student:

_____ is cleared for sports/co-curricular participation

_____ Is NOT cleared for sports/co-curricular participation

_____ Deferred

Physician: _____ M.D.

Date of Physical: _____

NOTE: Hospital, Clinic or Doctor's Stamp REQUIRED

Comments on Screening Exams: _____

Comments on Medical History: _____