SEGERSTROM HS 2025-2026

ATHLETICS MEDICAL SCREENING FORM

Last Name:_____ **First:** _____ **DOB:**_____

Gender : Male / Female **Student ID #**_____ **Grade:**_____

HEALTH HISTORY : TO BE COMPLETED BY STUDENT-ATHLETE AND PARENT PRIOR TO MEDICAL SCREENING EVALUATION.

Head injury, concussion, loss of memory, unconsciousness, persistent headaches	❒ Yes	❒ No
Bone/joint disorders (broken bones, dislocations, swelling, disease, surgery, arthritis)	❒ Yes	❒ No
Anemia, leukemia, bleeding disorders	❒ Yes	❒ No
Kidney/bladder problems	❒ Yes	❒ No
Eye problems	❒ Yes	❒ No
Ulcers, stomach trouble	❒ Yes	❒ No
Heart trouble, heart murmur, high blood pressure, rheumatic fever	❒ Yes	❒ No
Asthma, tuberculosis, bronchitis	❒ Yes	❒ No
Ulcers, stomach trouble	❒ Yes	❒ No
Allergies (Foods, medicines, insects, etc.)	❒ Yes	❒ No
Seizures, dizzy spells, fainting or convulsions	❒ Yes	❒ No
Diabetes, hepatitis, jaundice	❒ Yes	❒ No
Hernia	❒ Yes	❒ No
Taking medications (If yes, please list medication, dose, and frequency below)	❒ Yes	❒ No
COVID-19	❒ Yes	❒ No
If yes, please provide details:		

MEDICAL SCREENING EVALUATION: MUST BE COMPLETED BY A PHYSICIAN AFTER MAY 1, 2025

❒ **CLEARED FOR FULL PARTICIPATION**	❒ **NOT CLEARED FOR PARTICIPATION: SPECIALIST CLEARANCE REQUIRED**

MD RECOMMENDATIONS OR RESTRICTIONS:

BP	**HR**	**HT**	**WT**	**EYE CHART: R L**	**GLASSES/CONTACTS**	**BRACES/TEETH**

HEENT	**HEART**	**LUNGS**	**ABDOMEN**	**HERNIA**	**BACK**	**EXTREMITIES**

MD PHONE NUMBER ( )	**MD PRINT NAME**	**MD STAMP (REQUIRED)**
PHYSICAL EXAM DATE (REQUIRED)	**MD SIGNATURE (REQUIRED)**	

PARENT CONSENT, ACKNOWLEDGEMENT, SIGNATURE, & DATE *Required

CONSENT: By signing below, I hereby give my permission for a screening evaluation.

ACKNOWLEDGEMENT: I hereby give my consent for [above named student], hereafter named student, to compete in athletics. I authorize the student to go with and be supervised by a representative of the school on any trips. In case this student becomes ill or is injured, you are authorized to have the student treated and I authorized the medical agency to render treatment. I consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under, the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or said hospital it is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of the school representative to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. This authorization shall remain effective until the end of the school year unless sooner revoked in writing and delivered to the school. **I furthermore acknowledge that I have reviewed and provided online signatures at athleticclearance.com for all SAUSD and Segerstrom Athletics forms and waivers to participate in sports.**

Parent Signature_____ **Date** _____