

PLEASANTON UNIFIED SCHOOL DISTRICT

Physical Release Form

School _____ Male Female Grade _____
 Student's Name _____ ID# _____ Birthdate _____
 Address _____ Telephone _____

HEALTH DATA: To be filled in by parent or guardian. This report is confidential.

I. IMMUNIZATIONS AND TEST RECORD. Dates last given.

Series Dates	Boosters	(Mo. day & year)
POLIO _____, _____, _____, _____, _____.		
DPT-DT _____, _____, _____, _____, _____.		
MEASLES _____		HEP. B _____, _____, _____
RUBELLA _____ or MMR _____.		
MUMPS _____		
CHICKEN POX _____	Had disease _____	

M.D. Signature _____

II. HEALTH HISTORY (please check)

- | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> ASTHMA
<input type="checkbox"/> DIABETES
<input type="checkbox"/> EPILEPSY
<input type="checkbox"/> POLIOMYELITIS
<input type="checkbox"/> RHEUMATIC FEVER
<input type="checkbox"/> SCARLET FEVER
<input type="checkbox"/> RECURRENT BOILS
<input type="checkbox"/> TUBERCULOSIS
<input type="checkbox"/> CEREBRAL PALSY
<input type="checkbox"/> GERMAN MEASLES (3 DAY) | <input type="checkbox"/> MEASLES
<input type="checkbox"/> EAR TROUBLE
<input type="checkbox"/> HEARING LOSS
<input type="checkbox"/> DEFECTIVE VISION
<input type="checkbox"/> WEAR GLASSES
<input type="checkbox"/> FREQUENT HEADACHES
<input type="checkbox"/> 4 OR MORE COLDS PER YEAR
<input type="checkbox"/> FREQUENT LEG OR JOINT PAIN
<input type="checkbox"/> SHORTNESS OF BREATH
<input type="checkbox"/> DIZZINESS OR BLACKOUTS | <input type="checkbox"/> SPEECH DIFFICULTY
<input type="checkbox"/> LAMENESS
<input type="checkbox"/> ALLERGY
<input type="checkbox"/> PERSISTENT COUGH
<input type="checkbox"/> HERNIA
<input type="checkbox"/> FREQUENT NOSEBLEED
<input type="checkbox"/> TIRES EASILY
<input type="checkbox"/> OTHER (PLEASE SPECIFY) _____ |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Has your son or daughter had contact with Tuberculosis? Yes No
 If yes, to whom _____ Last Contact _____
 List any other serious illness, operation, or injury and the age
 when this happened. _____

DENTAL HISTORY

- DENTAL BRIDGE
 FALSE TEETH
 ORTHODONTIA

Has your son or daughter ever been advised not to participate in competitive athletics? Yes No
 If yes, why? _____

III. ADJUSTMENT IN REGULAR PROGRAM

Do you feel that your son or daughter has any physical problems which would necessitate restriction in physical education? Yes No
 Explanation: _____

IV. PROFESSIONAL HEALTH CARE

Name of Physician _____ Date of last visit _____

Name of Dentist _____ Date of last visit _____

Please add any information that might help school staff assist your child in his/her adjustment to school life.

DATE _____ SIGNATURE OF PARENT _____

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Student's Name _____

I hereby give my permission for my son or daughter to participate fully in the school athletic program.

Signed _____
Father, Mother, or Legal Guardian

PHYSICIANS FINDINGS AND RECOMMENDATIONS

I. FINDINGS

Heart: (a) Murmurs No Yes Describe _____ (b) Rhythm _____

(c) Pulse rate _____ Recovery Rate _____
At rest after exercise Satisf. Unsatisf.

(d) Blood Pressure _____ Height _____ Weight _____

Hernia _____ Urinalysis _____

Tetanus toxide given _____
Date

II. RECOMMENDATIONS

In my opinion, this student may participate in all interschool competitive sports.

In my opinion, this student may participate in all interschool sports,
except: _____
Name of Sport or Sports

FOR PHYSICAL EDUCATION (CHECK)

- 1. Any activity including competitive intramural and interschool games
- 2. Any activity except swimming.
- 3. Regular physical education without intramural and/or interschool games.
- 4. Modified physical education — Activities organized to fit individual needs.

Modifications and comments: _____

REASON FOR MODIFICATION _____

MODIFICATION IF RECOMMENDED FOR (CHECK)

- 1 week 2 weeks 1 month 2 months 6 months semester year

FOR ACADEMIC PROGRAM (CHECK)

- Lip reading instruction Speech correction Home instruction teacher
- Better adjustment of academic program to student interest and capacity.
- Reduction of pressure of class work. Help in social adjustment.
- Other adjustments and comments: _____

DATE _____ PHYSICIAN'S SIGNATURE _____

Print Physician's Name _____