California Youth Challe*NG*e Academy Sports Physical Form

SECTION A (to be completed by STUDENT):			☐ CAJC ☐ DCA ☐ GYA ■ SYA	
NAME OF STUDENT (LAST, FIRST, MIDDLE):			SOCIAL SECURITY NUMBER:	
ADDRESS:			DATE OF BIRTH (MM/DD/YYYY):	
CITY:	STATE:	ZIP CODE:	SEX:	AGE:

MEDICAL HISTORY (PAST & CURRENT) PLEASE CHECK YES OR NO FOR EACH MEDICAL CONDITION. IF YOU CHECK YES, WRITE THE YEAR IN THE BOX, AND **HAVE THE PHYSICIAN EXPLAIN IN SECTION B.**

	YES	NO	YEAR		YES	NO	YEAR		YES	NO	YEAR
ASTHMA				EATING DISORDER				GALL BLADDER TROUBLE			
SHORTNESS OF BREATH				RECENT WEIGHT GAIN/LOSS				GALLSTONES			
CHEST PAIN/PRESSURE				SWOLLEN /PAINFUL JOINTS				JAUNDICE OR HEPATITIS			
CHRONIC COUGH				ARTHRITIS/RHEUMATISM				SKIN DISEASE/INFECTION			
HEART PALPITATION				BURSITIS				TUMOR/GROWTH/CYST			
POUNDING HEART				BONE/ JOINT DEFORMITY				CANCER/ CHEMOTHERAPY			
HEART TROUBLE				LOSS OF FINGER/TOE				RADIATION THERAPY			
LOW BLOOD PRESSURE				BROKEN BONES				HERNIA			
HIGH BLOOD PRESSURE				PAINFUL/"TRICK" SHOULDER				HEMORRHOIDS			
FREQUENT HEADACHES				PAINFUL/"TRICK" ELBOW				RECTAL DISEASE			
SEVERE HEADACHES				LOCK/"TRICK" KNEE				FREQUENT URINATION			
DIZZINESS				BACK PAIN				PAINFUL URINATION			
FAINTING SPELLS				ANY TYPE OF BACK INJURY				BED WETTING SINCE AGE 12			
MEMORY LOSS/AMNESIA				BACK BRACE				KIDNEY STONE			
UNCONSCIOUSNESS				WRIST BRACE				BLOOD IN URINE			
HEAD INJURY/CONCUSSION				KNEE/ANKLE BRACE				BLOOD DISORDERS			
SINUSITIS				CRAMPS IN YOUR LEGS				DIABETES TYPE I			
WEAR CORRECTIVE LENSES				FOOT TROUBLE				DIABETES TYPE II			
EYE SURGEY				PLATE/PIN/ROD IN BONE				SLEEPWALKING			
NO VISION IN EITHER EYE				NERVE INJURY				TROUBLE SLEEPING			
EYE TROUBLE				HISTORY OF PARALYSIS				PSYCHIATRIC ISSUES			
WEARING A HEARING AID				EPILEPSY OR SEIZURE				DEPRESSION			
HEARING LOSS				CAR/SEA/AIR SICKNESS				SUICIDE ATTEMPT			
EAR INFECTIONS				FREQUENT INDIGESTION				HOSPITALIZATIONS			
TOOTH/GUM TROUBLE				STOMACH TROUBLE				HISTORY OF COUNSELING			
THYROID TROUBLE				INTESTINAL TROUBLE				HISTORY OF THERAPY			
GOITER TROUBLE				LIVER TROUBLE				POSITIVE TUBERCULOSIS			

SECTION B (to be completed by licensed physician, physician assistant, nurse practitioner):

PLEASE EXPLAIN ANY REPORTS OF MEDICAL ISSUES AS REPORTED IN THE MEDICAL HISTORY SECTION A. IF POSITIVE TB, DESCRIBE TREATMENT AND PROVIDE A CHEST X-RAY REPORT DONE AFTER 09 JAN 2021

SECTION B (continued):

PHYSICAL EXAM (NAME OF STUDENT):

DATE OF EXAM:	HEIGHT (IN):	WEIGHT (LB):	BLOOD PRESSURE:	HEART RATE:

PLEASE LIST ANY FOOD ALLERGIES:	TYPE OF REACTION:
PLEASE LIST ANY MEDICATION ALLERGIES:	TYPE OF REACTION:

PLEASE LIST ANY CURRENT MEDICATIONS:	DOSAGE:	ROUTE:

PLEASE PROVIDE A COPY OF THE STUDENT'S UPDATED IMMUNIZATION RECORD. STUDENT MUST HAVE THE FOLLOWING IMMUNIZATIONS FOR ADMITTANCE INTO A CHALLENGE YOUTH ACADEMY:

Tdap (Adacel within 10 years)

Meningococcal Group B

MMR 1 AND 2

Seasonal Flu

MCV4 Booster

HPV

TB Test (administered after 15 JAN 2021)
If positive TB Test, a chest x-ray report must be done after 09 JAN 2021

THE STUDENT CAN FULLY PARTICIPATE AT A CHALLENGE YOUTH ACADEMY WITHOUT ANY PHYSICAL RESTRICTIONS.	☐ YES ☐ NO

TYPED OR PRINTED NAME OF PHYSICIAN: (MUST BE MD, DO, PA, NP)	STAMP OF EXAMINING FACILITY:
SIGNATURE	
DATE:	