Health Examination Form

The health examination form is required by the state of California in order to participate in High School athletics. It must be completed every year, and each physical is good for 12 months of participation.

Example: A physical dated May 12, 2019 would make the athlete eligible until May 12, 2020. Starting May 13, 2020 the athlete would need a new physical and doctors confirmation before being allowed to participate.

The best ways to submit the health examination form are as follows:

- Scan and email it to: rgreenfield@kehillah.org
- Mail it to Kehillah: 3900 Fabian Way, Palo Alto, 94303, Ref: Ryan Greenfield
- Turn in a hard copy, please make sure it's labeled with my name on it
- Fax it to Kehillah: 650.213.9601 (Doctors offices are usually willing to do this, but there are often delays)

Suggestions:

- Complete the document in advance, this form takes the longest
- Make sure that the doctor has signed the document
- Make a copy of the document in the off-chance that it is lost in transit

KEHILLAH JEWISH HIGH SCHOOL

ATHLETIC PROGRAM HEALTH EXAMINATION FORM

(Give this to the doctor to complete during student athlete's physical exam, no earlier than 5/24/19

Please return all forms to Ryan Greenfield by mail, by dropping them off at the front desk of the school during normal summer business hours (10:00am – 4:00pm), or by e-mail to Ryan Greenfield at RGreenfield@kehillah.org. **All documents must be submitted before athletes can participate.**

Student's Name Last	First	AGE	BIRTHDATE
Address	City	Zip	Phone #

Parent/Guardian Name (please print)	Parent/Guardian Signature	Date

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ALL INFO BELOW & ON 2nd PAGE MUST BE COMPLETED BY PHYSICIAN

IMMUNIZATION RECORD

This record must be filled out by physician. It must include both month and year to be complete.
It is a requirement of the State of California that all health forms be up-to-date.

VACCINE	1st	2nd	3rd	4th	5th	Booster
Polio (OPV or IPV)	/ /	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/DT/Td (Diphtheria, tetanus and (acellular) pertussis OR tetanus and diphtheria only)	/ /	/ /	/ /	/ /	/ /	/ /
MMR (Measles, mumps, and rubella)	/ /	/ /				
Hepatitis B	/ /	/ /	/ /			
Varicella (Chickenpox)	/ /	/ /				

Last tetanus shot given ______________ Date of Physical Examination ______________________________

Have any tests or immunizations listed above caused severe illness? _____ Yes _____ No

TB SKIN TEST

Type*	Date given	Date read	mm indur	Impression
__ PPD-Mantoux			__________	__ Pos
__ Other	/ /	/ /	__________	__ Neg

*Must be Mantoux unless exception granted by local health department.

Chest X-Ray (Necessary if skin is positive.)
Film date: / / Impression: __ Normal __ Abnormal

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MEDICAL HISTORY

IF STUDENT HAS HAD ISSUES WITH ANY OF THE FOLLOWING, CHECK YES AND EXPLAIN UNDER COMMENTS. IF NOT, CHECK NO.

COMMENTS

Seizures? _____ Yes _____ No ____

Speech, Hearing or Visual Difficulty? _____ Yes _____ No ____

Diabetes? _____ Yes _____ No ____

If yes, specify medication and if student brings his/her medication supplies to school.

Heart or Pulmonary? _____ Yes _____ No ____

Orthopedic? _____ Yes _____ No ____

Allergy? _____ Yes _____ No ____

Does student carry a kit? _____ Yes _____ No ____

Is student on medication? _____ Yes _____ No ____

HAS THE STUDENT HAD ANY PREVIOUS DISEASES, OPERATIONS OR INJURIES THAT LIMIT HIM/HER FROM PARTICIPATION IN THE FOLLOWING ACTIVITIES?

Classroom Activities _____ Yes _____ No ____

Physical Education _____ Yes _____ No ____

Competitive Athletics _____ Yes _____ No ____

Is there an emotional or physical condition for which this student should remain under periodic medical observation?

_____ Yes _____ No ____

Is this student subject to fainting spells?

_____ Yes _____ No ____

Does this student have any learning disability problems?

_____ Yes _____ No ____

Height: ____________

Weight: ____________

Check ( ) if negative; otherwise please comment. COMMENTS AND RECOMMENDATIONS

Skin ( )

Muscalature ( )

Reflexes ( ) ____

Posture and Body Alignment ( )

Gait and extremities ( ) ____

Ears ( )

Hearing Loss? ( )

Eyes ( )

Vision: 20/_____ 20/_____

Throat (tonsils, etc.) ( ) ____

Lungs ( )

Heart ( )

Blood Pressure _________

Pulse Rate at Rest ____

Abdomen ( )

Hernia ( ) ____

External Genitalia ( ) ____

Teeth ( ) ____

DISEASES: (check if student has had history of disease or condition)

Chicken Pox	( )	Heart Disease	( )	Allergies, such as	
German measles	( )	Asthma	( )	to Penicillin	( )
Mumps	( )	Rheumatic Fever	( )	to Bee Stings	( )
Whooping Cough	( )	Epilepsy	( )	to Poison Oak	( )
Diabetes	( )				

THIS STUDENT/ATHLETE IS MEDICALLY FREE TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS: Yes _____ No _____

RESTRICTIONS: (IF ANY) ____

Physician Name & Address (print or stamp) ____

Physician Signature ____________________________ Date ________________________

Kehillah Jewish High School

3900 Fabian Way, Palo Alto, CA 94303 T (650) 213-9600 www.kehillah.org