DOCTORS
MEDICAL CENTER
A COMMUNITY BUILT ON CARE

MODESTO CITY SCHOOLS
PRE-PARTICIPATION SPORTS SCREENINGS
FOR 7-12 STUDENTS

Doctors Medical Center is gearing up for the 2023/2024 Grades 7-12 Sports Season! DMC will provide free pre-participation screenings for all MCS junior high & high school students on:

Tuesday, July 11, 2023
8:30am – 6:00pm
(See Assigned Time Slot Below)
Gregori High School Gym
3701 Pirrone Road, Modesto

Tuolumne TK-8/Beyer High—8:30 am to 10:00 am

La Loma Junior High/Downey High—10:00 am to 11:30 am

Roosevelt Junior High/Davis High—11:30 am to 1:00 pm

Hanshaw Middle/Johansen High—1:00 pm to 2:30 pm

Mark Twain Junior High/Modesto High—2:30 pm to 4:00 pm

Enochs High—4:00 pm to 5:00 pm

Gregori High—5:00 pm to 6:00 pm

Students must bring completed signed Athletic Physical Cards with them to the screenings. Parents must sign the cards. For more information about the screenings please contact your Athletic Director or Coach.

Parents attending will be able to fill out the forms at the day of the event. The times for schools to attend are for parents and students to meet athletic director and coaches. Athletes may attend any of the other times if necessary.

For question please contact.

Steve Blickenstaff
Blickenstaff.st@monet.k12.ca.us

School of Attendance: 6_____ 7_____ 8_____

Student ID #_____

MODESTO CITY SCHOOLS
JUNIOR HIGH SCHOOL ATHLETIC PHYSICAL SCREENING

Print Name_____ Birthday_____
Last *First* *Month* *Day* *Year*

Home Phone Number_____ Father's Work Phone_____ Mother's Work Phone_____

Do you have a doctor who you see regularly? ☐ Yes ☐ No If yes, name_____ Phone Number_____

Do you have insurance? ☐ Yes ☐ No If yes, carrier_____ Policy Number_____

Team Participation

FALL	☐ Football	☐ Volleyball (G)	☐ Cheer
WINTER	☐ Basketball (B/G)	☐ Soccer (B/G)	☐ Wrestling
SPRING	☐ Softball (G)	☐ Track (B/G)	☐ Volleyball (B) ☐ Baseball (B)

Explain "Yes" answers below.

Circle questions you don't know the answers to

		6th		7th		8th	
		Y	N	Y	N	Y	N
1.	Have you had a medical illness or injury since your last check up or sports physical?						
2.	Do you have an ongoing or chronic illness?						
3.	Have you ever been hospitalized overnight?						
4.	Have you ever had surgery?						
5.	Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?						
6.	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?						
7.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?						
8.	Have you ever had a rash or hives develop during or after exercise?						
9.	Have you ever passed out during or after exercise?						
10.	Have you ever been dizzy during or after exercise?						
11.	Have you ever had chest pain during or after exercise?						
12.	Do you get tired more quickly than your friends do during exercise?						
13.	Have you ever had racing of your heart or skipped heartbeats?						
14.	Have you had high blood pressure or high cholesterol?						
15.	Have you ever been told you have a heart murmur?						
16.	Has any family member of relative died of heart problems or of sudden death before age 50?						
17.	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?						
18.	Has a physician ever denied or restricted your participation in sports for any heart problems?						
19.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?						
20.	Have you ever had a head injury or concussion?						
21.	Have you ever been knocked out, become unconscious, or lost your memory?						
22.	Have you ever had a seizure?						
23.	Do you have frequent or severe headaches?						
24.	Have you ever had numbness or tingling in your arms, hands, legs, or feet?						
25.	Have you ever had a stinger, burner, or pinched nerve?						
26.	Have you ever become ill from exercising in the heat?						
27.	Do you cough, wheeze, or have trouble breathing during or after activity?						

		6th		7th		8th	
		Y	N	Y	N	Y	N
28.	Do you have asthma?						
29.	Do you have seasonal allergies that require medical treatment?						
30.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?						
31.	Have you had any problems with your eyes or vision?						
32.	Do you wear glasses, contacts, or protective eyewear?						
33.	Have you ever had a sprain, strain, or swelling after injury?						
34.	Have you broken or fractured any bones or dislocated any joints?						
35.	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?						

if yes, check appropriate box and explain below

☐ Head	☐ Neck	☐ Back
☐ Chest	☐ Shoulder	☐ Upper arm
☐ Elbow	☐ Forearm	☐ Wrist
☐ Hand	☐ Finger	☐ Hip
☐ Thigh	☐ Knee	☐ Shin/calf
☐ Ankle	☐ Foot	

36. Do you want to weigh more or less than you do now?
37. Do you lose weight regularly to meet weight requirements for your sport?
38. Do you feel stressed out?
39. Record the dates of your most recent immunizations (shots) for:
Tetanus_____ Measles _____ Hepatitis B _____ Chickenpox _____

FEMALES ONLY

40. When was your first menstrual period?
41. When was your most recent menstrual period?
42. How much time do you usually have from the start of one period to the start of another?
43. How many periods have you had in the last year?
44. What was the longest time between periods in the last year?

EXPLAIN "YES" ANSWERS HERE:

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct

6- Signature of Athlete_____ Signature of parent/guardian_____ Date_____

7- Signature of Athlete_____ Signature of parent/guardian_____ Date_____

8- Signature of Athlete_____ Signature of parent/guardian_____ Date_____

Print Name:_____ Birthday_____ Key X = Normal

Last First *Month Day Year*

Physical Screening	Grade 6	Grade 7	Grade 8
	Date_____	Date_____	Date_____
Height			
Weight			
Blood Pressure/Pulse	BP P	BP P	BP P
Vision	20/ 20/	20/ 20/	20/ 20/
APPEARANCE			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELATAL			
Neck			
Back/Spine			
Shoulder/Arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			
CLEARED			
NOT CLEARED			
Reason/Recommendation			
Cleared after completing evaluation/rehabilitation for			
Examiner's Signature			
Examiner's Name (please print)			
Examiner's Address			

Anticipatory Guidance		Y	N		Y	N		Y	N
	Injury Prevention			**Injury Prevention**			**Injury Prevention**		
	Psych/Social			**Psych/Social**			**Psych/Social**		
	Tobacco/Alcohol/ Drugs/Steroids			**Tobacco/Alcohol/** Drugs/Steroids			**Tobacco/Alcohol/** Drugs/Steroids		
	Eating Disorders			**Eating Disorders**			**Eating Disorders**		
	Diet/Fitness			**Diet/Fitness**			**Diet/Fitness**		
	Sexual Activity/ STD			**Sexual Activity/** STD			**Sexual Activity/** STD		