Central Valley Health District
*Nursing Department*
**Sports Physical Form**

Date: _____/_____/_____

| DEMOGRAPHICS | | | |
|---|---|---|---|
| Name: | | | Telephone Number: |
| Address: | | | City, State, Zip: |
| DOB: _____/_____/_____ | Sex: M F | Primary Physician: | Clinic: |

Race (Select all that apply):

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Native American or Pacific Islander
- ☐ Black or African American
- ☐ White
- ☐ Unknown

Ethnicity (Select minimum of one):

- ☐ Hispanic Origin
- ☐ Non-Hispanic Origin
- ☐ Unknown

| | | |
|---|---|---|
| Emergency Contact: | Relation: | Telephone Number: |

Tobacco Use: (Includes Vaping) ☐ Yes ☐ No

Exposed to Secondhand Smoke: ☐ Yes ☐ No

| INSURANCE INFORMATION | |
|---|---|
| Insurance Company: | Policy Holder: |
| Policy Number: | Policy Holder Date of Birth: |
| Group Number (if indicated): | ☐ Cash Price – Do not run insurance / No insurance |

## Consent & Authorization

I consent to undergo a sports physical evaluation as required for athletic participation. I understand that this examination helps assess my fitness for sports but does not replace regular medical care or guarantee the absence of health risks. I also authorize the release of a copy of the physical examination and medical history information to the school's athletic department and coaching staff as necessary for participation in sports.

By signing this document, I also acknowledge that I have received and/or reviewed a copy of Central Valley Health District's **Notice of Privacy Practices**.

_____ _____
Client Signature (If Over 18 Years Old) Date

_____
School

## Required if Client is Under 18:

_____
Parent/Guardian Name (Printed)

_____ _____
Parent/Guardian Signature Date

**DIGITAL FORM:**
*bit.ly/CVHDForms*