ATTENTION WISEBURN-DA VINCI WOLVES

IT’S TIME TO GET PHYSICAL

School & Sports Physicals

GET READY FOR A SEASON OF HEALTHY COMPETITION.

If your teen needs a physical exam for school or sports, we can help you ensure they are in good shape and ready for some healthy fun. Making sure you are healthy before participating in physical competition is the first step to victory, no matter your sport.

REGULAR PRICE $65

$30 THS PROMOTION
SPORTS PHYSICAL

AFC Urgent Care is proud to support Wiseburn Da Vinci School students by reducing the cost of Sports Physicals between August 5th - August 19th.

Receive an additional $5 off when you book your appointment on-line*.

$45 SUMMER SPECIAL

Unable to book during the promotion? No worries!
Book your appointment between June 15th and August 15th for your Summer Special!

*$5 off is during the promotional dates ONLY

Patient Services

- Sports Physicals
- X-rays
- Clinical Lab Testing
- STD Testing
- Routine Check-ups
- Flu Shots

Medi-Cal, MediCare and most private insurances.

AFC TORRANCE

310.868.8100 | afcurgentcare.com/torrance
Hours: M-F: 8am-8pm, S-S 8am-8pm

Book your appointment today for your $25 SPORTS PHYSICAL
WISEBURN DA VINCI HIGH SCHOOL PHYSICAL SCREENING FORM

SPORT: ___________ SCHOOL: WISEBURN DA VINCI DATE: _________

PRINT: Last Name First Name M.I. Grade Age Date of Birth

Address City Zip Code

HEALTH HISTORY (To be completed by student or parent):
Check and give as much information as possible  Y = yes,  N = no

___Heart Trouble  ___High Blood Pressure  ___Asthma  ___Diabetes
___Kidney Problems  ___Head Trauma  ___Seizures  ___Other (List below)

History of any previous injuries, fractures, serious illnesses or operations (Give year of problem)

Current medications Allergies Last Tetanus Immunization

Signature of Parent or Guardian: ____________________________

PHYSICAL EXAMINATION (To be completed by physician):

Height: _________ Weight: _________ Temp: _________ Blood Pressure: _________ Pulse: _________ Respiration: _________

Visual Acuity: O.D. ___/___  O.S. ___/___ ( ) Corrected ( ) Uncorrected  L.M.P. __________________________

( ) Chest Pain  ( ) Extreme S.O.B.  ( ) Dizziness  ( ) Fatigue  ( ) Palpitations  ( ) Sudden Death of Family Member

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<th>10. MUSCULOSKELETAL, ROM, STRENGTH</th>
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<td>2. EARS, NOSE, THROAT SHOULDER</td>
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<td>3. MOUTH AND TEETH ARMS/HANDS</td>
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<td>5. CARDIOVASCULAR THIGHS</td>
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<td>9. GENITALIA-HERNIA(MALE)</td>
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<td>11. NEUROMUSCULAR</td>
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ABNORMAL FINDING: ____________________________

RECOMMEND:  ( ) Full Activity, No Restrictions  Recommend:  ( ) Vision Evaluation ( ) Tetanus Booster

( ) Accept, Restrictions:  ( ) No contact sports  ( ) Other: ____________________________

( ) Not Participate

EXAMINING PHYSICIAN: ____________________________ License#: ____________________________ Date: _________

Address: ____________________________ ____________________________ Phone #: ____________________________

Doctor’s Stamp here:

* * * * * * THIS FORM MUST BE SIGNED * * * * * *