

I. STUDENT INFORMATION SECTION (Please Print)

Name _____ M ___ F ___ Date of Birth _____ Grade _____
 Address _____ City, State, Zip _____ Home/Cell Phone _____
 Mother's Name _____ Cell Phone # _____
 Father's Name _____ Cell Phone # _____

II. GRADES 6-12 ONLY: SPORTS (check all sports you are considering to participate in this year)

- | | | | | |
|--|---------------------------------------|-------------------------------------|--|---------------------------------------|
| FALL | | WINTER | SPRING | |
| <input type="checkbox"/> Football | <input type="checkbox"/> Cheerleading | <input type="checkbox"/> Basketball | <input type="checkbox"/> Baseball | <input type="checkbox"/> Tennis |
| <input type="checkbox"/> Cross-Country | <input type="checkbox"/> Volleyball | <input type="checkbox"/> Swimming | <input type="checkbox"/> Track and Field | <input type="checkbox"/> Girls Soccer |
| <input type="checkbox"/> Boys Soccer | | <input type="checkbox"/> Wrestling | <input type="checkbox"/> Golf | <input type="checkbox"/> Softball |

III. MEDICATIONS

Please list all prescribed medications: _____

Please list any health-related concerns (celiac, crohns, dietary, etc.): _____

IV. STUDENT MEDICAL HISTORY QUESTIONNAIRE

EXPLAIN "Yes" answers below (use back of form if necessary).

- | | Yes | No | Don't know |
|---|--------------------------|--------------------------|--------------------------|
| 1. Has the student ever been hospitalized or had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is the student presently taking any medications or pills? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does the student have any allergies (medicine, bees or other stinging insects, latex)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has the student ever passed out or nearly passed out DURING exercise, emotion or startle? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has the student ever fainted or passed out AFTER exercise? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Has the student had extreme fatigue associated with exercise (different from other children)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has the student ever been diagnosed with exercise-induced asthma? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has a doctor ever told the student that they have high blood pressure, heart infection, murmur, EKG? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has the student ever had discomfort, pain, or pressure in his chest during or after exercise or complained of their heart "racing" or "skipping beats"? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has the student ever had a head injury, been knocked unconscious, or had a concussion? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has the student ever had a seizure or been diagnosed with an unexplained seizure problem? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has the student ever had a stinger, burner or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has the student ever had a heat injury (heat stroke) or severe muscle cramps with activities? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Has the student ever had any problems with their eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Has the student ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury of any bones or joints? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Thigh <input type="checkbox"/> Neck <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Chest <input type="checkbox"/> Hip
<input type="checkbox"/> Forearm <input type="checkbox"/> Shin/calf <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> Hand <input type="checkbox"/> Foot <input type="checkbox"/> Other | | | |
| 16. Has the student ever had an eating disorder, or do you have any concerns about your eating habits or weight? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Does the student have any chronic medical illnesses (diabetes, asthma, kidney problems, etc.)? If yes, please explain. _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Has the student had a medical problem or injury since their last evaluation? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Does the student have the sickle cell trait (positive)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| FAMILY HISTORY | | | |
| 20. Has any family member had a sudden, unexpected death before age 50 (including from sudden infant death syndrome [SIDS], car accident, drowning)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Has any family member had unexplained heart attacks, fainting or seizures? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Does the student have a father, mother or brother with sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Explanation of any positive (yes) answers: _____

I have reviewed and answered each question above, and assure that all are accurate responses. Furthermore, I give permission for my child to participate in sports, if he/she chooses.

Signature of parent/legal custodian: _____ Date: _____

Signature of Student: _____ Date: _____

V. Carmel Christian School Physical Examination *(Completed by a Licensed Physician, Nurse Practitioner or Physician's Assistant)*

Student Name: _____ Age _____ Date of Birth _____

Height _____ Weight _____ BP _____ (_____% ile) / _____ (_____% ile) Pulse _____

Vision: R 20/____ L 20/____ Corrected: Y N (If yes, glasses _____ or/and contacts _____)

THESE ARE REQUIRED ELEMENTS FOR ALL EXAMINATIONS

	NORMAL	ABNORMAL	ABNORMAL FINDINGS
PULSE			
HEART			
LUNGS			
SKIN			
NECK/BACK			
SHOULDER			
KNEE			
ANKLE/FOOT			
Other Orthopedic Problems			
Other Concerns			

OPTIONAL EXAMINATION ELEMENTS – Should be completed, if history indicates

HEENT _____

ABDOMINAL _____

GENITALIA (MALES) _____

HERNIA (MALES) _____

KNOWN ALLERGIES AND RESPONSE REQUIRED: _____

Clearance:**

- A. Cleared
- B. Cleared after completing evaluation/rehabilitation for: _____
- C. Not cleared for: Collision Contact
 Non-contact ___Strenuous ___Moderately strenuous ___Non-strenuous

Due to: _____

Additional Recommendations/Rehab Instructions: _____

Print Name of Physician/Extender: _____

Signature of Physician/Extender _____ MD DO PA NP
(Signature and circle of designated degree required)

Date of exam: _____

Address: _____

Phone: _____

Physician Office Stamp:

*(** The following are considered disqualifying until appropriate medical and parental releases are obtained: post-operative clearance, acute infections, obvious growth retardation, diabetes, jaundice, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or hypertension, enlarged liver or spleen, a chronic musculoskeletal condition that limits ability for safe exercise/sport (i.e. Klippel-Feil anomaly, Sprengel's deformity), history of convulsions or concussions, absence of/ or one kidney, eye, testicle or ovary, etc.)*

