THIS MEDICAL EXAMINATION AND FORM MUST BE COMPLETED ANNUALLY AND BE ON FILE IN SCHOOL PRIOR TO ANY ATHLETIC PRACTICE OR COMPETITION

Please Print or Type

Student's Name: _____ _____ _____ Grade:_____
(Last) (First) (Middle)

Date of Physical: _____ Date of Birth: _____ Gender: M F Race _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Home Phone: _____

Father's Name: _____ Daytime Phone: _____ Page/Cell _____

Mother's Name: _____ Daytime Phone: _____ Page/Cell _____

Legal Guardian: _____ Daytime Phone: _____ Page/Cell _____

Alternate Emergency Contact:_____ Daytime Phone: _____ Page/Cell_____

Family Physician:_____ Phone #_____ Dentist:_____ Phone #_____

Insurance Company Name:_____ Policy Number/s: _____

Preferred Hospital: _____ Phone Number: _____

Medical Alerts: Are you allergic to any type of Medications, List:_____

Other allergic reactions, List:_____

Explain any other Medical condition that may pose problems for you during participation in activities:

_____

STUDENT'S NAME: _____ Date of Birth: _____

MEDICAL HISTORY:

Students and parents: This health record is a critical element in the determination of a student's risk of injury in extra-curricular activities. Please take the time to read and circle the correct responses before seeing a physician for the athlete's physical examination.

1.	Has anyone in the student's family (grandparents, mother, father, brother, sister, aunt, uncle) died suddenly before the age of 50?	YES		NO		DON'T KNOW
2.	Has the student ever stopped exercising because of dizziness or passed out during exercise?	YES		NO		DON'T KNOW
3.	Does the student have asthma (wheezing), hay fever or coughing spells after exercise?	YES		NO		DON'T KNOW
4.	Has the student ever broken a bone, had to wear a cast, or had an injury to any joint?	YES		NO		DON'T KNOW
5.	Does the student have a history of a concussion (or being knocked out)?	YES		NO		DON'T KNOW
6.	Has the student ever suffered a heat-related illness (such as heat stroke or exhaustion)?	YES		NO		DON'T KNOW
7.	Does the student have a chronic illness or see a doctor regularly for any particular reason?	YES		NO		DON'T KNOW
8.	Does the student take any medication(s)?	YES		NO		DON'T KNOW
9.	Is the student allergic to any medications, foods, or bee stings?	YES		NO		DON'T KNOW
10.	Does the student have only one of any paired organ (eyes, kidneys, testicles, ovaries, etc)?	YES		NO		DON'T KNOW
11.	Has the student had surgery or been hospitalized in the past year?	YES		NO		DON'T KNOW
12.	Has the student had an injury in the last year that caused the student to miss three or more consecutive days of practice or competition?	YES		NO		DON'T KNOW

13.	Has the student missed more than five consecutive days of participation in usual activities because of an illness, or has the student had a medical illness diagnosed that has not been resolved in the past year?	YES		NO		DON'T KNOW
14.	Are you, the student, worried about any problem or condition at this time?	YES		NO		DON'T KNOW
15.	Does the student have diabetes?	YES		NO		DON'T KNOW
16.	Is there a family history of diabetes?	YES		NO		DON'T KNOW

Please give details on any "YES" answer from the above health history on a separate (attached) sheet of paper.

PHYSICAL EXAM – TO BE COMPLETED BY PHYSICIAN

Height _____ Weight _____ Percent body fat (optional) _____ Pulse _____ Blood Pressure _____

Vision: R _____/_____ uncorrected R_____/_____corrected L_____/_____

	NORMAL	ABNORMAL FINDINGS	INITIALS
1. EYES			
2. EARS, NOSE, THROAT			
3. MOUTH & TEETH			
4. NECK			
5. CARIOVASCULAR			
6. CHEST & LUNGS			
7. ABDOMEN			
8. SKIN			
9. GENITALIA (MALE)			
10. MUSCULSKELETAL: ROM, Strength, etc.			
• Neck			
• Spine			
• Shoulders			
• Arms/hands			
• Hips			
• Thighs			
• Knees			
• Ankles			
• Feet			
11. Neuromuscular			
12. DIABETES	YES	NO	
IF YES, INSULIN-DEPENDENT?	YES	NO	

Comments re: Abnormal Findings:

_____

Please Print/Stamp

Physician's Name	
Street Address	
City, State, Zip Code	
Telephone	

I certify that I have examined this student and found him/her medically qualified to participate in sports activities. I also certify that I am a
licensed medical physician, physician's assistant, or family nurse practitioner in the United States. (Doctor of Chiropractic Medicine is not satisfactory).

Physician's Signature: _____ Date: _____

Request for Permission: We, the undersigned student and the student's parent/legal guardian, apply for permission to participate in the following sports and/or fine arts groups.

Please check which activities you are giving permission for your son or daughter to participate in.

( ) Baseball ( ) Soccer ( ) Basketball ( ) Golf
( ) Cheerleading ( ) Cross Country ( ) Volleyball

I (We) hereby permit my (our) son/daughter to participate on above marked teams and to engage in all activities related to the team, including, but not limited to, trying out, practicing, and playing in competitions. I (We) understand and assume all risks, which may include, but are not limited to sprains, fractures, ligament or cartilage damage, neck and spinal injuries, and serious injury to muscles, internal organs, and/or brain, associated with said participation. I (We) also recognize the importance of coaches' instructions regarding playing techniques, training guidelines and team rules. As part of this agreement to permit my (our) son/daughter to

participate on the above team(s), I (We) will not hold Bethesda Baptist Church, Bethesda Christian Academy or it's employees responsible in case of any reasonable accident or injury, whether caused by actual participation in the sport activity or as a result of vehicular accident traveling to or from the place of competition. I (We) acknowledge that we have been properly advised, warned, and cautioned by the administration and coaching personnel of Bethesda Christian Academy that participation in athletics can result in an athlete suffering serious injury. Having been so cautioned and warned, with full knowledge and understanding of the risk of serious injury from participation in athletics, it is our desire to consent to my (Our) son's/daughter's participation.

PARTICIPATION RESTRICTIONS:

Medical Authorization— In the event the designated preferred practitioner is not available, we authorize in advance another licensed physician or dentist the authority and power to render care in his/her best judgment and the transfer of the child to any hospital reasonably accessible. It is also understood that every effort shall be made to contact the parent/legal guardian prior to rendering treatment to the patient, but that treatment will not be withheld if the parent/guardian cannot be contacted. Permission is also granted for the school to provide emergency treatment to my/our child prior to his/her admission to any medical facility.

Risk of Injury - I hereby permit my son/daughter to participate on above marked teams and to engage in all activities related to the team, including, but not limited to, trying out, practicing, and playing in competitions. I understand and assume all risks, which may include, but are not limited to sprains, fractures, ligament or cartilage damage, neck and spinal injuries, and serious injury to muscles, internal organs, and/or brain (concussions), associated with said participation. I also recognize the importance of coaches' instructions regarding playing techniques, training guidelines and team rules. As part of this agreement to permit my son/daughter to participate on the above team(s), I will not hold Bethesda Baptist Church, Bethesda Christian Academy or its employees responsible in case of any reasonable accident or injury, whether caused by actual participation in the sport activity or as a result of vehicular accident traveling to or from the place of competition. I acknowledge that we have been properly advised, warned, and cautioned by the administration and coaching personnel of Bethesda Christian Academy that participation in athletics can result in an athlete suffering serious injury. Having been so cautioned and warned, with full knowledge and understanding of the risk of serious injury from participation in athletics, it is our desire to consent to my son's/daughter's participation.

We, the undersigned student and parent/legal guardian, certify that the information contained in this document is accurate and correct, and we agree to abide by the eligibility rules and regulations set by Bethesda Christian Academy, the Triangle Middle School Conference, and the State of North Carolina.

Student: _____ _____ Date _____
(Signature) (Printed Name of Student)

Parent: _____ _____ Date _____
(Signature) (Printed Name of Parent)

Legal Guardian: _____ _____ Date _____
(Signature) (Printed Name of Legal Guardian)