Carmel Christian school

2019-2020 Student Physical Form

*Please complete **ALL** pages of this form and return to the main school office before tryouts.*

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
- ❒ Football
- ❒ Cross-Country
- ❒ Boys Soccer
- ❒ Cheerleading
- ❒ Volleyball

WINTER
- ❒ Basketball
- ❒ Swimming
- ❒ Wrestling

SPRING
- ❒ Baseball
- ❒ Track and Field
- ❒ Golf
- ❒ Tennis
- ❒ Girls Soccer
- ❒ Softball

III. MEDICATIONS

Please list all prescribed medications: _____

_____

Please list any health-related concerns s(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?	❑	❑	❑
2. Is the student presently taking any medications or pills?	❑	❑	❑
3. Does the student have any allergies (medicine, bees or other stinging insects, latex)?	❑	❑	❑
4. Has the student ever passed out or nearly passed out DURING exercise, emotion or startle?	❑	❑	❑
5. Has the student ever fainted or passed out AFTER exercise?	❑	❑	❑
6. Has the student had extreme fatigue associated with exercise (different from other children)?	❑	❑	❑
7. Has the student ever been diagnosed with exercise-induced asthma?	❑	❑	❑
8. Has a doctor ever told the student that they have high blood pressure, heart infection, murmur, EKG?	❑	❑	❑
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"?	❑	❑	❑
10. Has the student ever had a head injury, been knocked unconscious, or had a concussion?	❑	❑	❑
11. Has the student ever had a seizure or been diagnosed with an unexplained seizure problem?	❑	❑	❑
12. Has the student ever had a stinger, burner or pinched nerve?	❑	❑	❑
13. Has the student ever had a heat injury (heat stroke) or severe muscle cramps with activities?	❑	❑	❑
14. Has the student ever had any problems with their eyes or vision?	❑	❑	❑
15. Has the student ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury of any bones or joints?	❑	❑	❑
❑Head ❑ Shoulder ❑ Thigh ❑ Neck ❑ Elbow ❑ Knee ❑ Chest ❑Hip			
❑Forearm ❑ Shin/calf ❑ Back ❑ Wrist ❑ Ankle ❑ Hand ❑ Foot ❑ Other _____			
16. Has the student ever had an eating disorder, or do you have any concerns about your eating habits or weight?	❑	❑	❑
17. Does the student have any chronic medical illnesses (diabetes, asthma, kidney problems, etc.)?	❑	❑	❑
If yes, please explain. _____			
18. Has the student had a medical problem or injury since their last evaluation?	❑	❑	❑
19. Does the student have the sickle cell trait (positive)?	❑	❑	❑
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)?	❑	❑	❑
21. Has any family member had unexplained heart attacks, fainting or seizures?	❑	❑	❑
22. Does the student have a father, mother or brother with sickle cell disease?	❑	❑	❑

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.)*