HERITAGE CHRISTIAN SCHOOL-DEPARTMENT OF ATHLETICS
PHYSICAL EXAMINATION SUMMARY

Name _____(M or F) ____ Age____ Phone_____Year_____
Address_____Zip___ _____ Year in School 6 7 8

Medical History Survey (to be completed by parent or guardian)

	Yes	No
Headache		
Heart		
Breathing, e.g.-asthma		
Abdominal pain		
Dizzy spells		
Black outs		
Eyes (except glasses)		
Hearing or ears		
Arthritis		
Joint pain or swelling		
Knees-injury, giving out, swelling		
Spine		
Broken bones		
Kidneys		
Bladder		
Diabetes		
High blood pressure		
Cancer		
Operations or surgery		
Varicose veins		
Skin disorders		
Other major injuries		
Drug allergies		

1. If you answered yes on the left, list details here.

2. Have you ever been knocked unconscious?
Yes ___ No ___
If yes, explain:

3. Have you ever had a cervical spine injury?
Yes ___ No ___
If yes, explain:

4. Do you have any permanent handicap or disability?
Yes ___ No ___
If yes, explain:

5. Are you under a physicians care at the present time?
Yes ___ No ___
If yes, explain:

6. Are you taking any medications or drugs at the present time?
Yes ___ No ___
Give details:

7. Have you had Tetanus immunizations?
Yes ___ No ___
Booster?
Yes ___ No ___ Date of Booster _____

8. Have you had a meningitis (Menactera) immunization?
Yes ___ No ___Date of immunization:_____

PARENTAL CONSENT (please sign)

I hereby give my consent for the above student to engage in physical education, intramurals, and interscholastic sports at Heritage Christian School. We also carry accident or health insurance with: _____
Signature: _____
Date:_____

THIS SIDE FOR EXAMINING PHYSICIAN ONLY

9. Eyes
   Right eye _____ Left eye _____

10. General Information
    Ht. _____ Wt. _____ B/P _____ Pulse _____

Examination:	Normal	Abnormal
11. Head		
12. Eyes		
13. Nose & throat		
14. Ears		
15. Neck		
16. Lungs		
17. Heart		
18. Abdomen		
19. Hernia		
20. G-U		
21. Extremity		
22. Shoulders		
23. Knees		
24. Nervous		
25. Knee laxity		
26. Other		

27. Right ___ MCL___LCL___ACL___PCL___
28. Left ___ MCL___LCL___ACL___PCL___

PHYSICIAN'S STATEMENT

29. Approved for sports: Yes___ No___

30. Approved pending further study. Explain:_____

_____

_____

31. Approved with limitations. Explain:_____

_____

_____

32. Disapproved. Comments:_____

_____

_____

33. Date_____ Signature_____