Chestertown Christian Academy
Athletic Department

MEDICAL EVALUATION OF STUDENT FOR PARTICIPATION IN INTERSCHOOL SPORTS

To be completed by Parent or Guardian and submitted to the examining physician before he examines the student.

Name of Student _____ DOB _____/_____/_____ School Year 20_____ - 20_____

Address _____

Parents _____

PERSONAL HEALTHOF STUDENT (check correct reply)

	YES	NO
1. Had had injuries or accident requiring medical attention?	_____	_____
2. Has had a surgical operation?	_____	_____
3. Has been in a hospital?	_____	_____
4. Has had sickness lasting longer than one week?	_____	_____
5. Takes medicine now or regularly?	_____	_____
6. Has a condition now under a physician's care?	_____	_____
7. Has a defect in hearing or eyesight? (wears glasses or contacts)	_____	_____
8. Is there any reason this student should not take part in sports?	_____	_____

If you answered yes to the any of the above questions, explain here with dates: _____

_____

_____

9. Has had complete poliomyelitis immunization by injections or vaccine by mouth?	_____	_____
10. Has had tetanus toxoid and booster inoculation.	_____	_____
11. Has seen a dentist within the past 6 months.	_____	_____
12. To my knowledge the paired organs that follow are present and healthy.		
EYES	_____	_____
EARS	_____	_____
LUNGS	_____	_____
KIDNEYS	_____	_____
TESTICIES/OVARIES	_____	_____
ARMS/LEGS	_____	_____
FINGERS/TOES	_____	_____

If you answered "NO" to any of the above questions, explain here with names and dates: _____

_____

I hereby give my consent for the above student to engage interschool sports activities as a representative of his/her school, except those activities crossed out by the examining physician on the reverse side of this form. I also, give my consent for the above student to accompany the team as a member for its away games and contests.

_____

I GIVE MY STUDENT PERMISSION FOR THE PHYSICIAN TO COMPELTE THIS FORM FOR THE CONFIDENTIAL USE IN MEETING MY STUDENT HEALTH AND EDUCATIONAL NEEDS.

_____ _____

Parent/Guardian Signature Date

Chestertown Christian Academy
Athletic Department

TO BE COMPLETED BY PHYSICIAN OR UNDER HIS SUPERVISION

Name of Student _____
last first mi

Grade _____

Significant past illness or injuries _____

PHYSICIAN'S EXAMINATION: (Circle and explain abnormal findings)

Height _____ Weight _____ Blood Pressure_____ Pulse_____

Eyes_____ Visual Activity _____/_____/_____

Ears _____ Hearing _____

Nose (deformities) _____ Oropharynx _____

Teeth (cavities, dentures, braces) _____ Cardiovascular (pedal pulse)_____

Breasts (M & F) _____ Respiratory _____

Abdomen (hernia, spleen, liver) _____ Genitalia and anus _____

Neuromuscular _____ Skin _____

Spine (cervical, thoracic, lumbar) _____

Extremities (special attention to the knees and ankles) _____

Additional explanation of abnormal findings _____

Urinalysis: Protein _____ Sugar _____ Other _____

Laboratory: Tuberculin Test _____ Chest X-Ray _____

Other Lab Tests_____

I have on this date personally examined this pupil, reviewed his history and other data recorded on both sides of this form, and find this student physically able to compete in supervised activities listed below which are NOT CROSSED OUT.

Baseball	Basketball	Football	Golf	Gymnastics	Lacrosse	Soccer
Softball	Swimming	Tennis	Track/Cross Country	Volleyball		

_____ _____ _____
Signature of Physician Date Phone

_____
Printed Name of Physician