

## 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 6-8 ONLY: SPORTS *(check all sports you are considering to participate in this year)*

- |                                              |                                                   |                                                                 |
|----------------------------------------------|---------------------------------------------------|-----------------------------------------------------------------|
| <b>FALL</b>                                  | <b>WINTER</b>                                     | <b>SPRING</b>                                                   |
| <input type="checkbox"/> Co-ed Cross-Country | <input type="checkbox"/> Boys Basketball          | <input type="checkbox"/> Girls Soccer                           |
| <input type="checkbox"/> Boys Soccer         | <input type="checkbox"/> Girls Basketball         | <input type="checkbox"/> Baseball (based on interest)           |
| <input type="checkbox"/> Girls Volleyball    | <input type="checkbox"/> Cheerleading (tentative) | <input type="checkbox"/> Boys Flag Football (based on interest) |

## 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<br><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.)?<br>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"/> |
| <b>FAMILY HISTORY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                          |                          |                          |
| 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. Grace Covenant Academy 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.)*