LIFE CHRISTIAN ACADEMY PHYSICAL EXAMINATION FORM

NAME OF STUDENT _____ SEX _____ DATE OF BIRTH _____ GRADE _____

PARENT OR GUARDIAN _____

HOME ADDRESS _____ HOME TELEPHONE _____ WORK TELEPHONE _____

PARENT OR GUARDIAN

STUDENT HEALTH HISTORY

Parent or Guardian, please answer only "Yes" or "No" to the following questions.

	YES	NO
CHRONIC AND/OR RECURRENT ILLNESS?		
HOSPITALIZATIONS?		
OPERATIONS?		
TAKING MEDICATIONS?		
ORGANS MISSING?		
HEAT EXHAUSTION?		
DIZZINESS, FAINTING, SEIZURES?		
KNOCKED OUT?		
CONCUSSION?		
WEAR GLASSES/CONTACTS?		
HEARING PROBLEMS?		
ALLERGIC TO MEDICATION?		
OTHER ALLERGIES?		
HIGH BLOOD PRESSURE?		
HERNIA?		
BONE, JOINT, SPINE INJURY?		
LIVER, SPLEEN, KIDNEY, OR SKIN PROBLEM?		

EXPLAIN ANY "YES" ANSWERS OR ANY OTHER PERTINENT INFORMATION CONCERNING HEALTH HISTORY.

☐ CHECK HERE IF ADDITIONAL COMMENTS ARE ON THE REVERSE SIDE

The above information is correct to the best of my knowledge. I hereby give my informed consent for the above named student to participate in activities. I understand the risk of injury in athletic participation. If my son/daughter becomes Ill or is injured, necessary medical care can be instituted by physicians, coaches, trainers or other personnel properly trained.

X / /

SIGNATURE OF PARENT / GUARDIAN DATE

PHYSICIAN

STUDENT HEALTH EXAMINATION

VITALS	SATISFACTORY YES	SATISFACTORY NO	EXAM COMMENTS	FOLLOW-UP
HEIGHT				
WEIGHT				
BLD PRESSURE				
PULSE				
GENERAL				
HEAD				
EYES				
EARS				
DENTAL				
CHEST				
HEART				
ABDOMEN				
GENITALIA				
SKIN				
EXTREMITIES				
BACK & NECK				

SUMMARY OF COMMENTS

☐ CHECK HERE IF ADDITIONAL COMMENTS ARE ON THE REVERSE SIDE

SPORTS PARTICIPATION APPROVED:

YES _____ NO _____ DEFERRED _____

LIMITATIONS OR FOLLOW-UP:

X / /

SIGNATURE OF PHYSICIAN DATE