FAITH CHRISTIAN ACADEMY
STUDENT'S MEDICAL HISTORY
(To be completed by parent or guardian prior to examination)

Have you ever had:

YES	NO	1. Chronic or recurrent illnesses? (Diabetes, Asthma, Seizures…)	YES	NO	11. Have any problems with heart/blood pressure?
YES	NO	2. Any hospitalization?	YES	NO	12. Or has anyone in your family ever fainted during exercise?
YES	NO	3. Any surgery (except tonsils)?	YES	NO	13. Take any medicine? List _____-_____
YES	NO	4. Any injuries that prohibited your participation in sports?	YES	NO	14. Wear glasses ____ Contact Lenses ____ Dental appliances ____?
YES	NO	5. Dizziness, fainting, or frequent headaches?	YES	NO	15. Have any organs missing? (eye, kidney, etc.)
YES	NO	6. Concussion/Knocked out?	YES	NO	16. Has it been longer than 10 years since your last tetanus shot?
YES	NO	7. Knee, ankle, or back injures?	YES	NO	17. Have you ever been told not to participate in sports?
YES	NO	8. Broken bones or dislocation?	YES	NO	18. Do you know of any reason this student should not participate in sports?
YES	NO	9. Heat exhaustion/sun stroke?	YES	NO	19. A sudden death history in your family?
YES	NO	10. Have any allergies?	YES	NO	20. Have a family history of heart attack before age 50?

Please explain any "YES" answerers or any other additional concerns:

_____

_____

_____

_____

_____

_____

_____

_____

I also give my consent for the physician in attendance and the appropriate medical staff to give treatment at any athletic event for any injury.

_____ _____

Signature of Parent or Guardian Date

FAITH CHRISTIAN ACADEMY
PHYSICIAN'S CERTIFICATE/PHYSICAL EXAM

Name: _____ Birthdate: _____

Height: _____

Weight: _____

Pulse: _____

Blood Pressure: _____

Visual acuity: Uncorrected _____/_____ Corrected _____/_____ Pupils equal Diameter Y N

Mouth: Appliances: Y N Missing/loose teeth: Y N Cavities in need of treatment: Y N

Skin: Any infectious lesion? Y N

Respiratory: Symmetrical breath sounds: Y N Wheezes: Y N

Cardiovascular: Rate _____ Irregularities: _____

Murmur: Y N Murmur with valsalva: Y N

Abdomen: Masses: Y N Splenomegaly: Y N Hepatomegally: Y N

Genitourinary: Inguinal hernis: Y N Testicles descended bilaterally: Y N

Musculoskaistal: (Note any abnormalities)

Neck:	Y	N	Knee/Hip:	Y	N
Shoulder:	Y	N	Ankle:	Y	N
Elbow:	Y	N	Hamstrings:	Y	N
Wrist:	Y	N	Scoliosis:	Y	N

Recommendations based on above evaluation:

_____

_____

_____

_____

_____

After my evaluation, I give my:

___ Full approval

___ Full approval: but needs further evaluation by family __Dentist__ Eye Doctor __ Family Physician__ Other

___ Limited approval with the following restrictions: _____

___ Denial of approval for the following reasons: _____

_____

Signature of M.D. – D.O. Date