

COMMUNITY CHRISTIAN SCHOOL

Health Examination Form

Expiration Date (for Athletic Office use only) _____

Parents: This form must be completed by you and your physician and turned in to the coach or the office prior to the first practice. Failure to do so will result in the student being denied participation in competition until it is completed. **This form is to be retained by the school after being completed by a registered physician. Please PRINT.**

I. STUDENT INFORMATION:

Name _____ Male Female
 Grade _____ Date of Birth _____ Height _____ Weight _____
 Address _____

Street
City
Zip

	<u>Yes</u>	<u>No</u>
Family member under 50 – heart attack or heart problems?	<input type="checkbox"/>	<input type="checkbox"/>
Medications currently being taken? What? _____	<input type="checkbox"/>	<input type="checkbox"/>
Medical conditions currently under treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Allergies (drugs/food/clothing/medications/insects/ice)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had an illness, condition or injury that: required hospital overnight, emergency room, x-rays?	<input type="checkbox"/>	<input type="checkbox"/>
required an operation?	<input type="checkbox"/>	<input type="checkbox"/>
caused you to see a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
caused you to miss several games or practices?	<input type="checkbox"/>	<input type="checkbox"/>
Any permanent deformity or disability?	<input type="checkbox"/>	<input type="checkbox"/>
Mental disorder or convulsions?	<input type="checkbox"/>	<input type="checkbox"/>
Fracture or other disabling injuries?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever “passed out” or been “knocked out?”	<input type="checkbox"/>	<input type="checkbox"/>

II. PHYSICAL BY A LICENSED STATE MEDICAL DOCTOR

Eyes _____ Right 20/ _____ Left 20/ _____	Hearing _____ Right 15/ _____ Left 15/ _____
Respiratory _____	Cardiovascular _____
Liver _____ Spleen _____ Hernia _____	Muscular/Skeletal _____
Skin _____	Neurological _____
Genitalia _____	

Completed Immunization Dates:

Polio _____ Measles/Mumps/Rubella _____ Tetanus _____

I certify that I have on this date examined this student and found him/her physically able to compete in supervised activities NOT CROSSED OUT BELOW:

Volleyball Soccer Basketball Other _____

Physician's Signature

Date

Please stamp Physician's Name/Address/Phone:

Athletic Permission Form

III. CONSENT FOR EMERGENCY CARE AND FINANCIAL RESPONSIBILITY

- A. Be it known that I, the undersigned parent/guardian of the applicant for interscholastic athletic participation, do hereby give and grant unto any medical doctor or hospital my consent and authorization to render such aid, treatment or care to said student as, in the judgment of said doctor or hospital, may be required on an emergency basis, in the event said student should be injured or stricken ill while participating in an athletic activity conducted by Community Christian School.
- B. Community Christian School and employees shall not be held liable for personal injury occurring as a result of participation in an athletic activity.

IV. TRANSPORTATION PERMISSION

Applicant has permission to ride in transportation provided by Community Christian School for all activities.

V. INSURANCE COVERAGE

It is understood that as a parent/legal guardian, I accept full financial responsibility regarding medical treatment. I/We, as parent(s) or legal guardian(s) assume full financial responsibility for any emergency care as consented to above.

Community Christian School has a student accident policy that covers medical expenses after the family's insurance. In the event of an injury where there is no primary insurance coverage, the parents/guardians should contact the office.

STUDENT NAME _____ PHONE _____

ADDRESS _____

Emergency Contact Numbers and Insurance Information:

Mother's Place of Employment:

Phone _____

Father's Place of Employment:

Phone _____

Family Physician:

Phone _____

Family Dentist:

Phone _____

Name of Private Insurance Carrier:

Policy Number(s) _____

I hereby give my permission for the above-named student to practice and compete and represent the school in interscholastic sports except those restricted on the reverse side, and as parent/legal guardian of the above-named student, I agree to be financially responsible for the safe return of all athletic equipment/uniforms issued to him/her. I further grant permission for my son or daughter, named above, to be given immediate emergency care in case of injury as the result of athletic competition by a physician obtained by the coach or representative of Community Baptist Church and Christian School. I understand that all medical expenses will first be the responsibility of our private insurance carrier as explained in paragraph V above.

Signature of Parent/Guardian

Date