

**ATHLETIC HEALTH EXAMINATION FORM FOR HAMILTON HEIGHTS CHRISTIAN ACADEMY**

**This form must be filled out completely before student will be allowed to practice and/or compete.**

Student's Name: \_\_\_\_\_ Parent's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Student's Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

**HEALTH HISTORY**

**Students, please complete: Check Yes or No in appropriate boxes.**

	YES	NO	ANY:
1.			Chronic or recurrent illnesses?
2.			Illnesses lasting more than a week?
3.			Hospitalizations?
4.			Surgery other than tonsillectomy?
5.			Injuries requiring treatment by a physician?
6.			Problems with blood pressure or heart?
7.			Dizziness, fainting, convulsions or frequent headaches?
8.			Knee injury?
9.			Knee surgery?
10.			Ankle injury?
11.			Neck injury?
12.			Other joint sprains, dislocations, broken bones?
13.			Heat exhaustion or heat stroke?
14.			Concussions or unconsciousness?
15.			Allergies or allergic to any medicine (Penicillin, aspirin, etc.)?
16.			Are you taking any medication at the present time?
17.			Do you use drugs or alcohol?
18.			Do you wear eyeglasses or contact lenses?
19.			Do you wear any dental appliances such as braces, bridge or plates?
20.			Do you have to stop while running around 1/4 mile track twice?
21.			Have any members of your family, under age 50, had any heart or blood pressure problems?
22.			Has anyone in your family under age 50 died suddenly?
23.			Do you have any organs missing other than tonsils (appendix, eye, kidney)?

Date of last Tetanus (Lockjaw) shot? \_\_\_\_\_

**Parent/Guardian read and sign:** I certify that the information above is true and I consider him/her physically capable of participating in athletics. I hereby give my consent for the above named student: (1) to represent his/her school in athletic activities, except for those exceptions cited by the examining physician, provided that such athletic activities are approved by the administration, (2) to accompany the school team of which he/she is a member on any of its local or out-of-town trips. I further authorize the school to obtain any emergency medical care that may become necessary for the student in the course of such athletic activities or such travel and understand that the cost of such treatment will be at my expense. Understanding that such activities involve the potential for catastrophic injury, or even death, which is inherent in all sports, I also agree not to hold Hamilton Heights Christian Academy or anyone acting on its behalf responsible for any injury occurring to the above named student in the course of such athletic activities or such travel. I also grant permission to Hamilton Heights Christian Academy to release any and all athletic injury information relating to the above named student to the Sports Medicine Program Injury Registry.

SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_ Date: \_\_\_\_\_

**Student's Statement of Voluntary Participation:** I hereby state that this application to compete in interscholastic athletics for the above school is entirely voluntary on my part and is made with the understanding that such activities involve the potential for catastrophic injury, or even death, which is inherent in all sports. I further state that I have not violated any of the eligibility rules and regulations.

SIGNATURE OF STUDENT \_\_\_\_\_ Date: \_\_\_\_\_

**PHYSICAL EXAMINATION**  
**Physician to complete this side of form**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse Rate: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_/\_\_\_\_\_

Vision: (without glasses) Rt \_\_\_\_/\_\_\_\_ Lt \_\_\_\_/\_\_\_\_ (with glasses) Rt \_\_\_\_/\_\_\_\_ Lt \_\_\_\_/\_\_\_\_

	NML	ABNL	COMMENTS	EX. INTS.
1. Cardio-Pulmonary				
2. Abdomen				
3. Genitalia-Hernia				
4. Skin-Lymphatics				
5. Spine				
6. Musculo-Skeletal				
7. Neurological				
8. HEENT				

Urinalysis (dipstick) (optional) \_\_\_\_\_ Fat % \_\_\_\_\_ Hematocrit/Hemoglobin (optional) GMS \_\_\_\_\_ % \_\_\_\_\_

**RECOMMENDATIONS**

\_\_\_\_\_ There were no findings in the Health History or on this Physical Examination which would prohibit this student from participating in interscholastic athletics.

\_\_\_\_\_ This student must have the following health problem(s) evaluated prior to participating in interscholastic athletics:

---



---



---

**To Student Athlete's Parent/Guardian:** During the pre-participation athletic health screening examination, the above health problem(s) was identified in your son/daughter. This health problem(s) must be evaluated by a physician of your choice before your son/daughter may participate in interscholastic athletics.

**To Examining Physician:** Upon completion of your examination and evaluation of this student for the health problem(s) listed above, please list your diagnosis, check one of the appropriate spaces and sign this form.

**DIAGNOSIS:** \_\_\_\_\_

---

\_\_\_\_\_ May participate in interscholastic athletics with no restrictions.

\_\_\_\_\_ May participate, but with the following specific limitations: \_\_\_\_\_

---

\_\_\_\_\_ May not participate in interscholastic athletics.

Physician's Address: \_\_\_\_\_ Physician's Phone: (\_\_\_\_) \_\_\_\_\_

**PHYSICIAN'S SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_