

**HEALTH EXAMINATION**

(Must be Completed by a Licensed Physician, Nurse Practitioner, or Physician Assistant)

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP ( \_\_\_\_\_ %) / ( \_\_\_\_\_ %) Pulse \_\_\_\_\_

Vision R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected: Y N

These are required elements for all examinations

	NORMAL	ABNORMAL	DESCRIBE ABNORMALITIES
PULSES			
HEART			
LUNGS			
SKIN			
NECK/BACK			
SHOULDER			
KNEE			
ANKLE/FOOT			
Other orthopedic Problems			

Optional Examination Elements - Should be done if history indicates

HEENT			
ABDOMINAL			
GENITALIA (MALES)			
HERNIA (MALES)			

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

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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## SOUTHVIEW CHRISTIAN SCHOOL ATHLETIC PARTICIPATION & EXAMINATION FORM

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This form is to be filled out completely before the student can participate in the school athletic programs.

### STUDENT INFORMATION (To be completed by the student)

NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
CITY STATE ZIP

PARENT'S NAME: \_\_\_\_\_ TELEPHONE NUMBER \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_ TELEPHONE NUMBER \_\_\_\_\_

I hereby apply for permission to participate in the following interscholastic sports:

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I certify that the information in the application is correct, and I agree to abide by the eligibility rules and regulations governing athletics as set forth by the North Carolina Christian Activities Association

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Date

### MEDICAL HISTORY (To be completed by the parents)

STUDENT: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

Is there a known history of:

- A. Birth deformities (one eye, one kidney, etc.)
- B. Known past illness of more than one week's duration?
- C. Medical conditions currently under treatment?
- D. Fractures or other disabling injuries?
- E. Any permanent deformity or disability?
- F. Allergy (drugs, food, clothing, etc.)?
- G. Mental disorder or convulsions?

Explain any above questions answered "yes" \_\_\_\_\_

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### PARENTAL PERMISSION

As parent or legal guardian of \_\_\_\_\_, I hereby give my consent for (his/her) practice and play in the athletic events listed above.

I also grant permission for treatment deemed necessary for a condition arising during participation in these activities, including medical or surgical treatment recommended by a medical doctor. I understand that every effort will be made to contact me prior to treatment.

I agree to the need for a screening medical examination and certify that the medical history above is accurate to the best of my knowledge.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date