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ATHLETICS PHYSICAL FORM

PART I – Permission (To be completed and signed by student and parent or legal guardian.)

Student Name_____ Date of Birth_____ Sex_____

Grade_____ Home Address_____ Phone_____

***Please list the BEST phone number to reach you after 3:00pm (cell, home, work, pager, etc.):

Mother_____ Father_____

Family Physician_____ Phone_____

Previous injuries (check all that apply including fractures, dislocations, and separations).
_____ Head/Neck/Shoulders _____ Upper/Lower Extremity _____ Torso

Please explain any injuries checked above.

_____

_____

Please list any previous surgery and date.

_____

Check if any applies. Have you ever:
____fainted, passed out, or been knocked out?

If yes, please explain_____

____had to stop running because of chest pain?

If yes, please explain_____

____had significant allergies to bee stings? If yes, please explain: _____

____had significant allergies to foods, medicines, others? If yes, please explain: _____

On medication for any of the above? ____ If yes, please list: _____

Continue to next page.

Check if any applies: Do you:

____have a prescription for the use of an inhaler? If yes, what type of asthma? _____

____have a prescription for the use of adrenaline? Any other allergy medicine? _____

____take any medicine regularly? If so, what type? _____

Is it a prescription? ____

____have any heart conditions or cardiac limitations? _____

____have any family member(s) with heart problems and/or heart attack or sudden death before the age of 50?

____have any missing or non-functioning organs such as testes, eye, kidney, etc.?

If yes, please explain: _____

____Females - have you begun menses yet? If so, please date when started:_____

____have any other significant health problems?_____

In sports, does your student wear:

_____ Eyewear (glasses, contact lenses, goggles)

_____ Mouth appliances (false teeth/plates, braces, retainer, etc.)

Does the above named student require at-school medications after 3 p.m. on practice and game days? _____

Please contact your student's Coach and the School Nurse for necessary documentation.

Sports interests (please check all that apply):
Fall: Boys Soccer ( ) Girls Volleyball ( )
Winter: Basketball ( )
Spring: Softball ( ) Coed Bowling ( ) Tennis ( )

Continue to next page.

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_____, has my/our permission to participate in the sports initialed above.
By my/our signature(s) approving participation, I/we also authorize Emergency Medical Treatment if required for my/our child as discussed below and the transport of my/our child to and from the athletic event site by a CBA school adult, volunteer parent driver, or contracted transportation. I/we understand and agree to abide by all of the
policies, procedures, and regulations contained in the Chesapeake Bay Academy Student and Parent Handbook.
Part I signifies that the medical history above is correct.

Parent/Guardian Signature(s) _____

Date_____

Student Signature_____
Date_____

Emergency Medical Treatment Authorization

I/we, being the parent(s)/legal guardian(s) of the above named child, hereby allow any member of the faculty, staff, or administration of Chesapeake Bay Academy to authorize the emergency medical treatment of my/our child at any hospital, clinic, or other certified medical facility, or by a licensed physician, paramedic, or other licensed medical personnel. The decision to submit the above named minor child to such emergency medical treatment is at the discretion of the above cited employees of Chesapeake Bay Academy. Furthermore, such discretion is to be exercised only when I/we or either of us cannot be reached at the above telephone numbers *unless*, at the discretion of the member of the faculty, staff, or administration, the situation is so serious as to warrant immediate medical attention. I/we understand that this assignment is made for the safety and benefit of my/our child and agree to hold harmless Chesapeake Bay Academy and its employees (1) for the negligence or wrongdoing of any hospital, clinic, or other certified medical facility, or any licensed physician, paramedic or other licensed medical personnel who may render care or treatment to my/our child; (2) for the selection of any such medical practitioner or facility; or (3) for any emergency treatment rendered by the employees of Chesapeake Bay Academy. Please note below known drug or other allergies that may require immediate treatment with epinephrine and/or Benadryl; currently taken medications; or other pertinent medical information:

_____

_____

_____

Preferred Hospital (IF conditions allow choice): _____

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PART II – Physical Examination Form (To be completed and signed by examining physician)
Please Print or Type.

Students Name _____
Last First Middle

Height_____ *Vision: Corrected (L)_____ (R)_____ Both_____

Weight_____ Uncorrected (L)_____(R)_____ Both_____

Pulse_____ resting _____exercise_____recovery_____

*Audiogram _____

*Urine: Glucose_____ Protein_____ Hemoglobin or HCT_____ Fe_____

Eyes_____ Cervical Spine/Neck_____

Ears_____ Back_____

Nose_____ Shoulders_____

Throat_____ Arms/elbows_____

Skin_____ Wrist/hand_____

Lymphatics_____ Knees_____

Heart_____ Hips_____

Lungs_____ Ankles/feet_____

Abdomen_____ Genitalia/Hernia_____

Peripheral pulses_____ *WHEN MEDICALLY INDICATED

Blood Pressure_____

Continue to next page.

Any recommendations/concerns on such items as:

- ❑ Daily medications?

  _____

- ❑ Weight loss, weight gain, or restrictions of weight loss?

  _____

- ❑ Heart or cardiac conditions/limitations?

  _____

- ❑ Slow or careful monitoring of conditioning because of overweight or abnormal exercise testing:

  _____

- ❑ Disability or permanent medical condition:

  _____

- ❑ Any other activity or situation of concern:

  _____

I certify that I have on this date examined this student and find him/her physically able to participate in all sports activities.

Date of examination:_____

Signature:_____

Physician name (print): _____

Physician's Address:_____

Physician's Phone: _____