VICTOR VALLEY CHRISTIAN SCHOOL

ATHLETIC PHYSICAL EXAMINATION FORM

Name _____ Sex _____ Age _____ Date of Birth _____

Address _____ Phone _____ Grade_____

Physician Name _____ Phone_____ Date of Examination_____

	Please Circle	
Have you had a medical illness or injury since your last check-up or sports physical?	Yes	No
1. Do you have an ongoing or chronic illness?	Yes	No
2. Have you ever been hospitalized overnight?	Yes	No
3. Have you ever had surgery?	Yes	No
4. Are you currently taking any prescription or nonprescription (over the counter) medications/pills or using an inhaler?	Yes	No
5. Have you ever taken any supplements or vitamins to help you gain/lose weight or improve your performance?	Yes	No
6. Do you have any allergies? (ex. pollen, medicine, food or stinging insects)	Yes	No
7. Have you ever had a rash or hives develop during or after exercise?	Yes	No
8. Have you ever passed out during or after exercise?	Yes	No
9. Have you ever been dizzy during or after exercise?	Yes	No
10. Have you ever had chest pain during or after exercise?	Yes	No
11. Have you ever had racing of your heart or skipped heartbeats?	Yes	No
12. Have you had high blood pressure or high cholesterol?	Yes	No
13. Have you ever been told you have a heart murmur?	Yes	No
15. Has any family member or relative died of heart problems or sudden death before age 50?	Yes	No
16. Has a physician ever denied or restricted your participation in sports for any heart problems?	Yes	No
18. Do you have any current skin problems? (ex. itching, rashes, acne, warts, fungus)	Yes	No
19. Have you ever had a head injury or concussion?	Yes	No
20. Have you ever been knocked out, become unconscious or lost your memory?	Yes	No
21. Have you ever had a seizure?	Yes	No
22. Do you have frequent or severe headaches?	Yes	No
23. Have you ever had numbness or tingling in your arms, hands, legs or feet?	Yes	No
24. Have you ever had a stinger, burner or pinched nerve?	Yes	No
25. Have you ever become ill from exercising in the heat?	Yes	No
26. Do you cough, wheeze or have trouble breathing during or after activity?	Yes	No
27. Do you have asthma?	Yes	No
28. Do you have seasonal allergies that require medical treatment?	Yes	No
29. Do you use any special protective or corrective equipment or devices that are not usually used for your sport or position (for example, knee brace, neck roll, foot orthotics, teeth retainer, hearing aid)?	Yes	No
30. Have you had any problems, with your eyes or vision?	Yes	No
31. Do you wear glasses, contacts, or protective eyewear?	Yes	No
32. Have you ever had a sprain, strain, or swelling after injury?	Yes	No
33. Have you broken or fractured any bones or dislocated any joint?	Yes	No
34. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? If yes, check box _Head _Elbow _ Hip _ Neck _ Forearm _ Thigh ___ Back _ Wrist _ Knee _ Chest __Hand _Shin/Calf __Shoulder __Finger __Ankle __Upper arm __Foot	Yes	No
35. Record the dates of your most recent immunizations: Tetanus_____		

Please explain all yes answers by question number _____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Date _____

Signature of parent/guardian _____ Date _____

VICTOR VALLEY CHRISTIAN SCHOOL
ATHLETIC PHYSICAL EXAMINATION FORM

(to be completed by physician)

DATE OF EXAMINATION _____

Name _____ Date of Birth _____ Grade _____

Height _____Weight _____Blood Pressure _____ Pulse _____

General Appearance: Good _____ Average _____ Less than Average _____

Stature: Slight _____ Medium _____ Heavy _____ Obese _____

Muscle Tone: Good _____ Average _____ Poor _____

Back, Shoulder or Extremity Deformity: No _____ Yes _____ Restrictive: No _____ Yes _____

Ears: Evidence of past or present disease: No _____ Yes _____ Eyes: Pupils regular: No _____ Yes _____ Corrected: No _____ Yes _____

EOM's normal: No _____ Yes _____ Nose Obstruction: None _____ Slight _____ Restrictive _____

Mouth and Teeth: Hygiene: Good _____ Fair _____ Poor _____ Cavities: No _____ Yes _____

Throat: Airway Unrestricted _____ Airway Restricted _____ Chest Excursion: Good _____ Fair _____ Poor _____

Lungs: Clear _____ Abnormality _____ Hernias: No _____ Yes _____

Heart Tones: Normal _____ Functional Murmur _____ Questionable Murmur _____

Referred to family physician for evaluation: No _____ Yes _____

Medical Conditions _____

A CHECK INDICATES NORMAL, ANY ABNORMALITIES, PLEASE EXPLAIN BELOW

Lymph Nodes _____ Abdomen _____ Back _____ Shoulder/Arm _____ Elbow/Forearm _____

Knee _____ Leg/Ankle _____Foot _____Wrist/Hand_____ Hip/Thigh _____

While this does not constitute a complete physical examination, this individual appears to be physically capable of participating in interscholastic sports as of this date, except as mentioned below

_____ Cleared for sports without restrictions

Cleared for sports with the following restrictions _____

Cleared for sports after completing evaluation/rehabilitation for _____

_____Not Cleared Recommendations _____

Examination Date _____ Physician's Signature _____ License No _____

Address _____ Phone _____

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Allergies _____
Other Information _____
Any medical conditions that VVCS should be aware of _____

Name of Family Physician _____
Address _____ Phone _____

Parents to read and sign-

Rules of Victor Valley Christian School indicate that a student participating in the athletic program must file a certification that he/she can participate without danger to his/her health and well-being. The top part of this form must be completed and signed by a physician or practitioner and then returned to the office. The selection of the practitioner to give the physical exam and make the certification was made by the undersigned parent(s). The parent(s) assumes responsibility for the accuracy of that certification, and acknowledges that the school is not responsible therefore.

_____ _____
Father/Guardian Name Printed Mother/Guardian Name Printed

_____ _____
Father/Guardian's Signature/Date Mother/Guardian's Signature/Date