Step of Faith Christian Academy

9009 Tarboro Road, PO Box 1449, Ridgeland, SC 29936 843-726-6100

CHARGERS ATHLETIC HEALTH EXAMINATION FORM

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

Student:_____ Parent: _____Cell Phone:_____

Home Address: _____ Home Phone: _____

Student's Age:_____ Date of Birth:_____ Grade:_____ Student Cell: _____

HEALTH HISTORY

Student history: Check Yes or No in appropriate boxes. If yes, please briefly explain and / or give dates.

	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 wear eyeglasses or contact lenses?_____
18.			Do you wear any dental appliances such as braces, bridge or plates? _____
19.			Do you have to stop while running around 1/4 mile track twice? _____
20.			Have any members of your family, under age 50, had any heart or blood pressure problems?
21.			Has anyone in your family under age 50 died suddenly?
22.			Do you have any organs missing other than tonsils (appendix, eye, kidney)?_____

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, and (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 Step of Faith 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 Step of Faith 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 in 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				

Date of last Tetanus (Lockjaw) shot? _____

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:** _____