RALEIGH CHRISTIAN ACADEMY
Medical History and Physical Examination for Athletics

Student Name:	Grade:	DOB:	☐ M	☐ F

STUDENT'S MEDICAL HISTORY *(completed by parent)*

Instructions:

1) This section (Page 1) is to be completed by the parent prior to the doctor visit
2) After completing Page 1, take to doctor on date of exam to complete Page 2 (back of this form
3) When both sides are completed and signed, turn in to coach or athletic director
4) Physical exams are valid for the current school year when completed after May 1 of the preceding school year. The exam is valid through June 30 of the current school year.

	Explain "Yes" answers below or on a separate page	Yes	No	Unsure
1.	Has the student ever been hospitalized or had surgery?			
2.	Is the student presently taking any medications?			
	Medications:			
3.	Does the student have any allergies (medicine, bees or other stinging insects, latex)?			
	Allergies:			
4.	Has the student ever passed out or nearly passed out **DURING** exercise, emotion, or startle?			
5.	Has the student ever fainted or passed out **AFTER** exercise?			
6.	Has the student had extreme fatigue associated with exercise (different from other children)?			
7.	Has the student ever had trouble breathing during exercise, or a cough with exercise?			
8.	Has the student evern been diagnosed with exercise-induced asthma?			
9.	Has a doctor ever told the student that he/she has high blood pressure?			
10.	Has a doctor ever told the student that he/she has a heart infection?			
11.	Has a doctor ever ordered an EKG or other test for the student's heart, or has the student ever been told he/she has a murmur?			
12.	Has the student ever had discomfort, pain, or pressure in his/her chest during or after exercise or complained of the heart "racing" or "skipping beats"?			
13.	Has the student ever had a head injury, been knocked out, or had a concussion?			
14.	Has the student ever had a seizure or been diagnosed with an unexplained seizure problem?			
15.	Has the student ever had a stinger, burner or pinched nerve?			
16.	Has the student ever had a heat injury (heat stroke) or severe muscle cramps with activities?			
17.	Has the student ever had any problems with eyes or vision?			
18.	Has the student ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury of any bones or joints? (Specify below)			
	☐ Head ☐ Shoulder ☐ Thigh ☐ Neck ☐ Elbow ☐ Knee ☐ Chest ☐ Hip			
	☐ Arm ☐ Shin/calf ☐ Back ☐ Wrist ☐ Ankle ☐ Hand ☐ Foot			
19.	Has the student ever had an eating disorder, or do you have any concerns about your eating habits or weight?			
20.	Does student have any chronic medical illnesses (diabetes, asthma, kidney problems, etc.)?			
21.	Has the student had a medical problem or injury since their last evaluation?			
22.	Does the student have the sickle cell trait?			
	FAMILY HISTORY			
23.	Has any family member had a sudden, unexpected death before age 50 (including from sudden infant death syndrome (SIDS), car accident, drowning)?			
24.	Has any family member had unexplained heart attacks, fainting or seizures?			
25.	Does the athlete have a father, mother or brother with sickle cell disease?			
26.	Is there a family history of diabetes?			

Elaborate on any **"Yes"** answers above:

I have reviewed and answered each question above, and assure that all are accurate responses. Furthermore, I give permission for my child to participate in the sports checked below:

☐ Basketball	☐ Baseball	☐ Cheerleading	☐ Cross Country	☐ Golf	☐ Soccer	☐ Volleyball

Signature of Parent/Legal Guardian: Date:

Signature of Student: Date:

Raleigh Christian Academy
Physical Examination for Athletics

PHYSICAL EXAMINATION

A physical exam is valid for the current school year if completed after May 1st of the preceding school year.
Exam is valid through June 30 of the current school year.

Exam must be completed by a Licensed Physician, Nurse Practitioner, or Physician's Assistant.
Doctor of Chiropractic Medicine is not satisfactory

Student's Name:		Age:	Date of Birth:
Date of Exam:		☐ Male	☐ Female
Height:	Weight:	BP:	Pulse:
Vision: R 20/	L 20/	Corrected? ☐ Yes	☐ No

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
EENT		
Lymph nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin		
Neurologic		
Neck/Back		
Shoulder		
Knee		
Ankle/Foot		
Other Orthopedic		

Clearance:

☐ **CLEARED WITHOUT RESTRICTIONS**

☐ **CLEARED with following notation:**

☐ Cleared **AFTER** documented further evaluation or treatment for:

☐ Cleared for **Limited Participation** (explain below):

☐ Not cleared for (specific sports): Until Date:

Reason(s):

☐ **NOT** cleared for participation (reason):

Additional Recommendations/Rehab Instructions:

Physician Signature/Degree MD DO PA LNP Date:

Address:

Phone:

Physician Office Stamp