EAGLE HEIGHTS CHRISTIAN ACADEMY
Pre-participation Sports Physical
Medical History

Student's Name________________________________ Gender M F Date of Birth_______________
Age at Exam_________ Grade __________ Phone #___________________
Student's Address ____
City_______________________State_________Zip Code________________________

This Medical History Form must be completed annually by parent (or guardian) and student in order to participate in athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

	Please Circle
1. Has student had a medical condition or injury since last physical?	Yes No Don't know
2. Has student been hospitalized overnight in the past year?	Yes No Don't know
3. Has the student ever stopped exercising because of dizziness or had shortness of breath or have they ever passed out during exercise?	Yes No Don't know
4. Has the student ever had chest pains during or after exercise?	Yes No Don't know
5. Does student ever get more tired than their friends during exercise?	Yes No Don't know
6. Does the student have asthma (wheezing,) hay fever or coughing spells after exercising?	Yes No Don't know
7. Has a physician every denied or restricted student's participation in any sport for any heart problems?	Yes No Don't know
8. Is the student taking any prescription, over the counter medication or inhaler?	Yes No Don't know
9. Has anyone in the student's family (mother, father, grandparents, brother, sister, aunts, uncles) died before age 50?	Yes No Don't know
10. Has any family member been diagnosed with enlarged heart Hypertrophic Cardiomyopathy, Marfan's Syndrome or abnormal heart rhythm?	Yes No Don't know
11. Has student ever had a head injury or concussion?	Yes No Don't know
12. Has student ever had a seizure?	Yes No Don't know
13. Does student have frequent or severe headaches?	Yes No Don't know
14. Has student ever had numbness or tingling in arms, legs, hands or feet?	Yes No Don't know
15. Has student every suffered from heat related illness (heat stroke)?	Yes No Don't know
16. Does student have seasonal allergies that require medical treatment?	Yes No Don't know
17. Has student ever had problems with eyes or vision?	Yes No Don't know
18. Is student missing any paired organs? (eyes, ears, kidneys, etc.)	Yes No Don't know
19. Has student ever broken a bone? Dislocated joints?	Yes No Don't know
20. Does student have a chronic illness or see a doctor regularly for any particular problem?	Yes No Don't know
21. Is student allergic to any insects or bee stings?	Yes No Don't know

Please explain all Yes answers here ____

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EAGLE HEIGHTS CHRISTIAN ACADEMY
Pre-participation Sports Physical

Females Only

When was your daughter's first menstrual period? ______________________________

When was her most recent menstrual period? _________________________________

How much time is in between each cycle? ____________________________________

Have there been any menstrual problems within the last year? _____________________

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains.

If in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize and consent to such care and treatment as may be given said student by any physician, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If between this date and the beginning of athletic competition, any illness or injury should occur that my limit this student's participation. I agree to notify the school authorities of such illness or injury.

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

Student's Signature ___________________________

Parent Signature _____________________________

Date ____

EAGLE HEIGHTS CHRISTIAN ACADEMY
Pre-participation Physical Evaluation Completed by Physician

Student's Name: ______________________________ Date of Birth ______________________
Height: _______ Weight: _______ Pulse: ________ BP ______/______ AN _________ BMI ______
Vision: R 20/_____ L 20/_____ Corrected: Y N Equal _____ Unequal _________

	Medical	Normal	Abnormal Findings	Initials
1	Appearance			
2	Eyes/Ears/Nose/Throat			
3	Lymph Nodes			
4	Heart-Auscultation of the heart in the supine position			
5	Heart-Auscultation of the hear in standing position			
6	Heart-Lower extremity pulses			
7	Pulses			
8	Lungs			
9	Abdomen			
10	Genitalia (males only)			
11	Skin			
	Musculoskeletal			
1	Neck			
2	Back			
3	Shoulder/Arm			
4	Elbow/Forearm			
5	Wrist/Hand			
6	Hip/Thigh			
7	Knee			
8	Leg/Ankle			
9	Foot			

*stationed-based examination only
Cleared Y N
Not Cleared for __________________________ Reason _____________________________________

Recommendations: ____

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This examination must be filled in and signed by either a Physician, a Physician Assistant Licensed by a State Board of Physician Assistant Examiners, or a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners. Examination forms signed by any other health care practitioner will not be accepted.

Name: (print/type) ___________________________ Date of Examination: ____________________

Address: ____

Phone Number: ____

Signature: ____