DeMotte Christian School Physical Form

Name of Student _____

School Year _____ Grade _____ Date of Birth _____ Age _____ F M

Address _____Phone _____

With whom do you live? (circle one) Parent; Guardian; Other _____

School Attended Last Semester _____

PART I – STUDENT CERTIFICATE (to be signed by student)

To the best of my knowledge, I have suffered no injury or illness in the past that would hinder my participation in my chosen sport/s.

Date _____ Student Signature _____

PART II – PARENT CONSENT (to be completed and signed by parent or guardian)

In accordance with the rules of DeMotte Christian School, I hereby give my consent for the above named student to participate in the following interschool sports: XC, Soccer, Volleyball, Basketball, Track.

I understand that participation may necessitate travel and early dismissal from classes. *Please check appropriate space:* He/She has school student accident insurance ( ); has adequate family insurance coverage ( ).

Date _____ Parent/Guardian Signature _____

Please Complete Student's Medical History (Part III) On Other Side of This Form

FILE IN SCHOOL OFFICE

Separate Form Required For Each School Year

PART III – STUDENT MEDICAL HISTORY (to be completed by parent or family physician)

Name of Student _____

Parents Name _____ Phone _____

Yes – No 1. Has had injuries requiring medical attention.
Yes – No 2. Has had illness lasting more than a week.
Yes – No 3. Is under physician's care now.
Yes – No 4. Takes medication now.
Yes – No 5. Wears glasses (contact lenses: yes – no)
Yes – No 6. Has had a surgical operation.
Yes – No 7. Has been in hospital (except for tonsillectomy)
Yes – No 8. Do you know any reason why the individual should not participate in all sports?
Yes – No 9. Congenital absence or loss of function of any normally "paired" organ (eye, kidney, etc.).
Yes – No 10. History of asthma.
Yes – No 11. Family history (immediate) of cardiac anomalies or conditions.
Yes – No 12. Allergies.
Yes – No 13. History of concussions.
Yes – No 14. History of neck injuries.
Yes – No 15. Syncope or fainting spells.

Please explain any "yes" answers to above questions.

_____

_____

Yes – No 16. Most recent tetanus toxoid immunization date _____

Parent or Physician's Signature _____

PART IV – PHYSICIAN'S CERTIFICATE

(The physical examination must be performed on or after April 1 by a physician holding an unlimited license to practice medicine, a nurse practitioner or a physician assistant to be valid for the following school year.)

Name of Student _____
Grade _____ Age _____ Height _____ Weight _____ Blood Pressure _____
Significant past illness or injury _____

Examination	Satisfactory	Unsatisfactory	Not Examined
Vision			
Hearing			
Respiratory			
Cardiovascular			
Liver, Spleen, Kidney			
Hernia, Genitalia			
Musculoskeletal			
Skin			
Neurological			
Lab Tests – Urinalysis			
Other			

I certify that I have, this date, examined this student as indicated and find him/her physically able to complete in the following supervised athletics: Basketball, Cross-Country, Track, Soccer, and Volleyball.

Physicians Address _____ **Phone** _____

Date of Examination _____ **Signed** _____**MD/DO/NP/PA**