

ATHLETICS PHYSICAL FORM**PART I – Permission** (To be completed and signed by student and parent or legal guardian.)

Student Name _____ Date of Birth _____ Sex _____

Grade _____ Home Address _____ Phone _____

***Please list the BEST phone number to reach you after 3:00pm (cell, home, work, pager, etc.):

Mother _____ Father _____

Family Physician _____ Phone _____

Previous injuries (check all that apply including fractures, dislocations, and separations).

____ Head/Neck/Shoulders ____ Upper/Lower Extremity ____ Torso

Please explain any injuries checked above.

Please list any previous surgery and date.

Check if any applies. Have you ever:

____ fainted, passed out, or been knocked out?

If yes, please explain _____

____ had to stop running because of chest pain?

If yes, please explain _____

____ had significant allergies to bee stings? If yes, please explain: _____

____ had significant allergies to foods, medicines, others? If yes, please explain: _____

On medication for any of the above? ____ If yes, please list: _____

Continue to next page.

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Check if any applies: Do you:

____ have a prescription for the use of an inhaler? If yes, what type of asthma? _____

____ have a prescription for the use of adrenaline? Any other allergy medicine? _____

____ take any medicine regularly? If so, what type? _____

Is it a prescription? _____

____ have any heart conditions or cardiac limitations? _____

____ have any family member(s) with heart problems and/or heart attack or sudden death before the age of 50?

____ have any missing or non-functioning organs such as testes, eye, kidney, etc.?

If yes, please explain: _____

____ Females - have you begun menses yet? If so, please date when started: _____

____ have any other significant health problems? _____

In sports, does your student wear:

____ Eyewear (glasses, contact lenses, goggles)

____ Mouth appliances (false teeth/plates, braces, retainer, etc.)

Does the above named student require at-school medications after 3 p.m. on practice and game days?

Please contact your student's Coach and the School Nurse for necessary documentation.

Sports interests (please check all that apply):

Fall: Boys Soccer () Girls Volleyball ()

Winter: Basketball ()

Spring: Softball () Coed Bowling () Tennis ()

Continue to next page.

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_____, has my/our permission to participate in the sports initialed above.

By my/our signature(s) approving participation, I/we also authorize Emergency Medical Treatment if required for my/our child as discussed below and the transport of my/our child to and from the athletic event site by a CBA school adult, volunteer parent driver, or contracted transportation. I/we understand and agree to abide by all of the policies, procedures, and regulations contained in the Chesapeake Bay Academy Student and Parent Handbook.

Part I signifies that the medical history above is correct.

Parent/Guardian Signature(s) _____

Date _____

Student Signature _____

Date _____

Emergency Medical Treatment Authorization

I/we, being the parent(s)/legal guardian(s) of the above named child, hereby allow any member of the faculty, staff, or administration of Chesapeake Bay Academy to authorize the emergency medical treatment of my/our child at any hospital, clinic, or other certified medical facility, or by a licensed physician, paramedic, or other licensed medical personnel. The decision to submit the above named minor child to such emergency medical treatment is at the discretion of the above cited employees of Chesapeake Bay Academy. Furthermore, such discretion is to be exercised only when I/we or either of us cannot be reached at the above telephone numbers unless, at the discretion of the member of the faculty, staff, or administration, the situation is so serious as to warrant immediate medical attention. I/we understand that this assignment is made for the safety and benefit of my/our child and agree to hold harmless Chesapeake Bay Academy and its employees (1) for the negligence or wrongdoing of any hospital, clinic, or other certified medical facility, or any licensed physician, paramedic or other licensed medical personnel who may render care or treatment to my/our child; (2) for the selection of any such medical practitioner or facility; or (3) for any emergency treatment rendered by the employees of Chesapeake Bay Academy. Please note below known drug or other allergies that may require immediate treatment with epinephrine and/or Benadryl; currently taken medications; or other pertinent medical information:

Preferred Hospital (IF conditions allow choice): _____

PART II – Physical Examination Form (To be completed and signed by examining physician)

Please Print or Type.

Students Name _____
Last First Middle

Height _____ *Vision: Corrected (L) _____ (R) _____ Both _____

Weight _____ Uncorrected (L) _____ (R) _____ Both _____

Pulse _____ resting _____ exercise _____ recovery _____

*Audiogram _____

*Urine: Glucose _____ Protein _____ Hemoglobin or HCT _____ Fe _____

Eyes _____ Cervical Spine/Neck _____

Ears _____ Back _____

Nose _____ Shoulders _____

Throat _____ Arms/elbows _____

Skin _____ Wrist/hand _____

Lymphatics _____ Knees _____

Heart _____ Hips _____

Lungs _____ Ankles/feet _____

Abdomen _____ Genitalia/Hernia _____

Peripheral pulses _____ *WHEN MEDICALLY INDICATED

Blood Pressure _____

Continue to next page.

Any recommendations/concerns on such items as:

- ☐ Daily medications?

- ☐ Weight loss, weight gain, or restrictions of weight loss?

- ☐ Heart or cardiac conditions/limitations?

- ☐ Slow or careful monitoring of conditioning because of overweight or abnormal exercise testing:

- ☐ Disability or permanent medical condition:

- ☐ Any other activity or situation of concern:

I certify that I have on this date examined this student and find him/her physically able to participate in all sports activities.

Date of examination: _____

Signature: _____

Physician name (print): _____

Physician's Address: _____

Physician's Phone: _____