



Calvary Christian School

101 Calvary Street, Greer, SC 29650
calvarychristiangreer.org
864.877.5555 ccseagle4031@yahoo.com

Pre-Participation Health Assessment

Name: _____ Date of Birth: _____

Address: _____

Person to notify in an emergency: _____ Phone: _____

Physician: _____ Phone: _____

School: _____ Phone: _____

HISTORY: TO BE COMPLETED BY STUDENT ASSISTED BY PARENT/GUARDIAN

(Circle One)

- 1. Yes No Did your parents, grandparents; brothers/sisters under age 50 have heart problems, or high blood pressure?
Have you ever had or do you have:
- 2. Yes No Heart Murmur, High Blood Pressure, Extra heart beats or heart abnormality?
- 3. Yes No Need for using medications? Please list: _____
- 4. Yes No Concussion or problems "passing out"?
- 5. Yes No Medicine allergy? Please list: _____
- 6. Yes No Any illness, injury, or condition that lasted more than a week?
- 7. Yes No Hospitalized or surgery? Why? _____
- 8. Yes No Dental appliance?
- 9. Yes No Contacts or glasses?
- 10. Yes No To stop running around a ¼ track twice?
- 11. Yes No An illness or injury that caused you to miss a game or practice?
- 12. Yes No Congenital absence or loss of function of one organ (eye, ear, kidney, etc.)? _____
- 13. Yes No Headaches (frequent)?
- 14. Yes No Asthma?
- 15. Yes No Convulsions (Seizures)? _____ How Many? _____
- 16. Yes No Neck or Spine injury? _____
- 17. Yes No Broken bones? _____
- 18. Yes No Sprains or dislocations? _____
- 19. Yes No Date of last tetanus shot (within last 10 years) _____
- 20. Yes No FEMALES: Have you had a period in the last 6 months? How many? _____
- 21. Yes No FEMALES: Do menstrual cramps keep you from regular activities?

Parental Permission

I give my permission for _____ to be a part of the 2019-2020 athletic/cheerleading programs. I understand that it is my responsibility as the athletes' parent(s) to provide insurance in the event of an injury while participating in practice/play of an organized school sport. The school will not assume any financial responsibility for injuries while participating on an athletic team.

Parent's Signature Date

Athlete's Signature Date

PHYSICIAN PLEASE COMPLETE THE FOLLOWING SECTION:

I have examined _____ on _____

Findings _____

Physician's Signature _____ Date: _____