Calvary Christian School
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Pre-Participation Health Assessment (6th-12th)

Name: _____ **Date of Birth:** _____

Address: _____

Person to notify in an emergency: _____ **Phone:** _____

Physician: _____ **Phone:** _____

School: _____ **Phone:** _____

HISTORY: TO BE COMPLETED BY PARENT/GUARDIAN AND STUDENT

(Circle Yes or No for each question)

1. Yes No Did your parents, grandparents, brothers, and/or 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? Details: _____
3. Yes No Medication(s) use? Please list: _____
4. Yes No Concussion or problems "passing out"? Details: _____
5. Yes No Allergy (medication, food, etc.)? Please list: _____
6. Yes No Any illness, injury, or condition that lasted more than a week? Details: _____
7. Yes No Hospitalized or surgery? Details: _____
9. Yes No Contacts or glasses? Please list: _____
10. Yes No A need to stop running around a ¼ track twice? Details: _____
11. Yes No An illness or injury that caused you to miss a game or practice? Details: _____
12. Yes No Congenital absence or loss of function of one organ (eye, ear, kidney, etc.)? Details: _____
13. Yes No Headaches (frequent)? How often? _____
14. Yes No Asthma?
15. Yes No Convulsions (Seizures)? How many/often? _____
16. Yes No Neck or Spine injury? Details: _____
17. Yes No Broken bones? Details: _____
18. Yes No Sprains or dislocations? Details: _____
19. Yes No Recent tetanus shot? Date of last tetanus shot (must be 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? If yes, how often? _____

Please give any further explanation/details needed for "yes" answers in the above questions: _____
_____
_____
_____

PARENTAL PERMISSION

I give my permission for _____to be a part of the 20__-20__ athletic/cheerleading programs. I understand that it is my responsibility as the athlete's parent 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 _____

PHYSICIAN, PLEASE COMPLETE THE FOLLOWING SECTION:

I have examined_____(student/patient name) to evaluate him/her for athletic participation.
Findings_____
_____
_____
_____

I certify that I have on this date examined this student and find him/her physically able to compete in the following supervised school activities:

(circle any/all that apply) Volleyball Basketball Cheerleading Other _____

Physician's Signature: _____Date: _____