



**NORTHWEST CHRISTIAN SCHOOLS
ELEMENTARY ATHLETIC PHYSICAL FORM
(INCLUDING 6TH GRADE)**

NAME _____ GRADE _____ SEX _____

Birth Date _____ Address _____

Parent's Phone (H) _____ (W) _____ (Cell) _____

Health Care Provider _____ Health Care Phone _____

Sports _____ Preferred Hospital _____

Notify in Emergency _____ Emergency Phone _____

Alternate Emergency Name _____ Alternate Phone _____

Parent Email Address _____

<p>Medications (taken regularly) _____ _____</p> <p>Last tetanus shot _____ (year)</p>	<p>Allergies</p> <p>Medicine <input type="checkbox"/> (specify _____)</p> <p>Bee sting <input type="checkbox"/></p>
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History

Explain "Yes" answers below:

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Have you had any medical problem or injury since your last evaluation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been in the hospital or had an operation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been dizzy or passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever had high blood pressure, a heart murmur or irregular heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Has anyone in your family died of heart problems or a sudden death before age 50 | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever been knocked out or unconscious, had a head injury, or a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had a "stinger," "burner," or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had muscle cramps, heat exhaustion or heat stroke? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you have trouble breathing or do you cough during or after activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had asthma, diabetes, mono, or other medical problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Are you missing an eye, kidney or testicle? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you use any special equipment (pads, braces, neck rolls, mouth guards, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever had a sprain, strain, dislocation, stress fracture, joint swelling, or broken bone? <input type="checkbox"/> | | <input type="checkbox"/> |
| <input type="checkbox"/> neck <input type="checkbox"/> back <input type="checkbox"/> shoulder <input type="checkbox"/> elbow <input type="checkbox"/> wrist <input type="checkbox"/> hand | | |
| <input type="checkbox"/> thigh <input type="checkbox"/> knee <input type="checkbox"/> shin/calf <input type="checkbox"/> ankle <input type="checkbox"/> hip <input type="checkbox"/> foot | | |
| 15. Are you satisfied with your weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. At what age was your first menstrual period? _____ Do you have at least 8 periods a year? <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Explain "Yes" answers: _____

Parent/Guardian: Please read and sign

I hereby state that, to the best of my knowledge, the answers to the above questions are correct. I approve of my child's participation in athletics at NWC Schools, Inc., athletic programs, and I will assume all financial responsibilities not covered by any school insurance I purchase for injuries received while he / she is training for or playing in athletic games. I also give permission for my child to receive a physical examination. I give my permission for my son / daughter to travel as required as a member of the team(s) of which he / she is a member. I give permission for emergency treatment of an injury by any physician designated by a school official.

Date _____ Signature of Athlete _____ Signature of Parent/Guardian _____

PHYSICAL EXAMINATION

Name _____ Age _____ Date _____

Sex _____ Height _____ Weight _____ Blood Pressure _____ / _____ Pulse _____

Vision R 20/ _____ L 20/ _____ Corrected Y N

	Normal	Abnormal Findings	Initials
HEENT			
Pupils equal?			
Heart			
Pulses			
Lungs			
Abdominal			
Testicles / hernia			
Musculoskeletal			
Neck			
Back			
Shoulder			
Elbow			
Wrist			
Hand			
Hip			
Knee		R MCL R ACL L MCL L ACL	
Ankle		R ANT DRAWER L ANT DRAWER	
Foot			

No restriction for sports participation

Clearance withheld pending attached verification of rehabilitation / evaluation for: _____

Limited participation. Not cleared for the following types of sports: _____

Recommendations: _____

Examiner's Signature _____ Date _____

Address _____ Phone _____