VICTOR VALLEY CHRISTIAN SCHOOL

ATHLETIC PHYSICAL EXAMINATION FORM

Name ________________________________ Sex ______ Age _______ Date of Birth ________________

Address ____ Phone ______________________ Grade____________

Physician Name ________________________ Phone________________ Date of Examination_________

	Please Circle	
Have you had a medical illness or injury since your last check-up or sports physical?	Yes	No
1. Do you have an ongoing or chronic illness?	Yes	No
2. Have you ever been hospitalized overnight?	Yes	No
3. Have you ever had surgery?	Yes	No
4. Are you currently taking any prescription or nonprescription (over the counter) Medications/pills or using an inhaler?	Yes	No
5. Have you ever taken any supplements or vitamins to help you gain/lose weight or improve your performance?	Yes	No
6. Do you have any allergies? (ex. pollen, medicine, food or stinging insects)	Yes	No
7. Have you ever had a rash or hives develop during or after exercise?	Yes	No
8. Have you ever passed out during or after exercise?	Yes	No
9. Have you ever been dizzy during or after exercise?	Yes	No
10. Have you ever had chest pain during or after exercise?	Yes	No
11. Have you ever had racing of your heart or skipped heartbeats?	Yes	No
12. Have you had high blood pressure or high cholesterol?	Yes	No
13. Have you ever been told you have a heart murmur?	Yes	No
15. Has any family member or relative died of heart problems or sudden death before age 50?	Yes	No
16. Has a physician ever denied or restricted your participation in sports for any heart problems?	Yes	No
18. Do you have any current skin problems? (ex. itching, rashes, acne, warts, fungus)	Yes	No
19. Have you ever had a head injury or concussion?	Yes	No
20. Have you ever been knocked out, become unconscious or lost your memory?	Yes	No
21. Have you ever had a seizure?	Yes	No
22. Do you have frequent or severe headaches?	Yes	No
23. Have you ever had numbness or tingling in your arms, hands, legs or feet?	Yes	No
24. Have you ever had a stinger, burner or pinched nerve?	Yes	No
25. Have you ever become ill from exercising in the heat?	Yes	No
26. Do you cough, wheeze or have trouble breathing during or after activity?	Yes	No
27. Do you have asthma?	Yes	No
28. Do you have seasonal allergies that require medical treatment?	Yes	No
29. Do you use any special protective or corrective equipment or devices that are not usually used for your sport or position (for example, knee brace, neck roll, foot orthotics, teeth retainer, hearing aid)?	Yes	No
30. Have you had any problems, with your eyes or vision?	Yes	No
31. Do you wear glasses, contacts, or protective eyewear?	Yes	No
32. Have you ever had a sprain, strain, or swelling after injury?	Yes	No
33. Have you broken or fractured any bones or dislocated any joint?	Yes	No
34. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? If yes, check box	Yes	No

_Head _Elbow _ Hip _ Neck _ Forearm _ Thigh ___ Back _ Wrist _ Knee _ Chest __Hand
_Shin/Calf __Shoulder __Finger __Ankle __Upper arm __Foot

35. Record the dates of your most recent immunizations: Tetanus______________________________________

____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ___________________________________ Date ____________

Signature of parent/guardian __________________________ Date ____________

VICTOR VALLEY CHRISTIAN SCHOOL
ATHLETIC PHYSICAL EXAMINATION FORM

(to be completed by physician)

DATE OF EXAMINATION ____________________________

Name ____ Date of Birth ______________ Grade _____________

Height ________Weight _________Blood Pressure __________ Pulse __________

General Appearance: Good ________ Average ________ Less than Average ________

Stature: Slight _____ Medium _____ Heavy _____ Obese _____

Muscle Tone: Good _____ Average _____ Poor ______

Back, Shoulder or Extremity Deformity: No _____ Yes _____ Restrictive: No _____ Yes _____

Ears: Evidence of past or present disease: No _____ Yes _____ Eyes: Pupils regular: No _____ Yes _____ Corrected: No _____ Yes _____

EOM's normal: No _____ Yes _____ Nose Obstruction: None _____ Slight _____ Restrictive _____

Mouth and Teeth: Hygiene: Good _____ Fair _____ Poor _____ Cavities: No _____ Yes _____

Throat: Airway Unrestricted _____ Airway Restricted _____ Chest Excursion: Good _____ Fair _____ Poor _____

Lungs: Clear _____ Abnormality _____ Hernias: No _____ Yes _____

Heart Tones: Normal _____ Functional Murmur _____ Questionable Murmur _____

Referred to family physician for evaluation: No _____ Yes _____

Medical Conditions ____

A CHECK INDICATES NORMAL, ANY ABNORMALITIES, PLEASE EXPLAIN BELOW

Lymph Nodes _____ Abdomen _____ Back ______ Shoulder/Arm ______ Elbow/Forearm ______

Knee ________ Leg/Ankle ___________Foot ____________Wrist/Hand__________ Hip/Thigh _________

While this does not constitute a complete physical examination, this individual appears to be physically capable of participating in interscholastic sports as of this date, except as mentioned below

______ Cleared for sports without restrictions

Cleared for sports with the following restrictions ____

Cleared for sports after completing evaluation/rehabilitation for ___________________________________

______Not Cleared Recommendations ____

Examination Date ________________ Physician's Signature __________________________________ License No ___________________

Address ______________________________________ Phone _______________________________

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Allergies ____

Other Information ____

Any medical conditions that VVCS should be aware of ____

Name of Family Physician ____

Address ____ Phone ______________________________

Parents to read and sign-

Rules of Victor Valley Christian School indicate that a student participating in the athletic program must file a certification that he/she can participate without danger to his/her health and well-being. The top part of this form must be completed and signed by a physician or practitioner and then returned to the office. The selection of the practitioner to give the physical exam and make the certification was made by the undersigned parent(s). The parent(s) assumes responsibility for the accuracy of that certification, and acknowledges that the school is not responsible therefore.

_______________________________________ _______________________________________

Father/Guardian Name Printed Mother/Guardian Name Printed

_______________________________________ _______________________________________

Father/Guardian's Signature/Date Mother/Guardian's Signature/Date