

HERITAGE CHRISTIAN SCHOOL ATHLETIC DEPARTMENT

Pre-Participation Screening Certificate

History and Physical **Date** _____
 Full Name of Student _____ **Birthdate** _____
 Age _____ Sex _____ Race: Black _____ White _____ Other _____
 Address _____ **Phone** _____
 Sport/Activity _____ **Grade** _____

History

(TO BE COMPLETED TO THE BEST OF THEIR KNOWLEDGE AND SIGNED BY PARENT/GUARDIAN AND STUDENT PRIOR TO PHYSICAL EXAMINATION.

WITHHOLDING OR FALSIFYING INFORMATION COULD LEAD TO SERIOUS MEDICAL COMPLICATIONS.)

- | | <i>Circle One</i> | | <i>If Yes, please explain</i> |
|---|-------------------|----|-------------------------------|
| 1. <i>Has the student ever:</i> | | | |
| (a) been knocked out? | Yes | No | _____ |
| (b) had a concussion? | Yes | No | _____ |
| (c) stayed overnight in a hospital? | Yes | No | _____ |
| (d) had an operation? | Yes | No | _____ |
| (e) had heat exhaustion or heat stroke? | Yes | No | _____ |
| (f) had a head or neck injury? | Yes | No | _____ |
| (g) had a back or spinal injury? | Yes | No | _____ |
| (h) had a heart murmur? | Yes | No | _____ |
| (i) had high blood pressure? | Yes | No | _____ |
| (j) had a heart problem? | Yes | No | _____ |
| (k) fainted while doing exercise? | Yes | No | _____ |
| 2. <i>Does the student:</i> | | | |
| (a) take medicine every day? | Yes | No | _____ |
| (b) wear glasses or contact lenses? | Yes | No | _____ |
| (c) wear dental appliances or hearing aids? | Yes | No | _____ |
| (d) have any allergies? | Yes | No | _____ |
| (e) have any chronic illnesses (i.e. diabetes, asthma, etc.)? | Yes | No | _____ |
| (f) have any body parts missing (i.e. kidney, finger, etc.)? | Yes | No | _____ |
| 3. <i>Has the student's father, mother, sister or brother had any heart problems before age 50?</i> | Yes | No | _____ |
| 4. <i>Has any physician limited the student's athletic participation?</i> | Yes | No | _____ |
| 5. <i>Has the student ever broken a bone or had a cast on the:</i> | | | |
| (a) hand? | Yes | No | _____ |
| (b) wrist? | Yes | No | _____ |
| (c) arm? | Yes | No | _____ |
| (d) foot? | Yes | No | _____ |
| (e) ankle? | Yes | No | _____ |
| (f) leg? | Yes | No | _____ |
| (g) other? | Yes | No | _____ |
| 6. <i>Has the student broken a bone while playing sports in the past year?</i> | Yes | No | Bone _____
Activity _____ |

The examination performed for this participation certificate is limited and is designed to identify common conditions or infirmities that would limit or prevent a student's participation in athletic activities. This examination is not intended to be comprehensive and may not detect some types of latent or hidden medical conditions. All athletes should receive periodic comprehensive medical examinations and prompt treatment for illnesses/injuries.

This is to certify that I have read and understand the above information and hereby give permission and consent to emergency medical treatment for my son/daughter/ward, and that the responses to the preceding questions are correct.

Signature of Parent/Guardian

Signature of Student

Physical Examination

(To be Completed by Physician)

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ (beats/min.)

Vision: Right _____ Left _____ Corrected _____ Uncorrected _____

Circle One

If Abnormal, Please Explain

Skin	Normal	Abnormal	
Head and Neck	Normal	Abnormal	
Eyes	Normal	Abnormal	
Ears, Nose, Throat	Normal	Abnormal	
Teeth and Mouth	Normal	Abnormal	
Lungs and Chest	Normal	Abnormal	
Cardiovascular	Normal	Abnormal	
Abdomen and Lymphatics	Normal	Abnormal	
Genitalia/Hernia	Normal	Abnormal	
Orthopedic Screening:			
Upper Extremities	Normal	Abnormal	
Lower Extremities	Normal	Abnormal	
Spine and Back	Normal	Abnormal	
Neurological	Normal	Abnormal	

Additional Comments:

No pupil shall be eligible to represent his/her school in interscholastic athletics unless there is on file in the school office a physician's statement for the current year certifying that the pupil has passed an adequate physical examination, and that in the opinion of the examining physician, he/she is fully able to participate in school athletics.

This is to certify that on this _____ day of _____, 20____, I performed the above limited examination on _____, and based upon an evaluation of the medical history provided and upon my limited examination, I am of the opinion that he/she IS _____ IS NOT _____ physically able to participate in ALL _____ LIMITED* _____ athletic events of the school.

_____, M.D.

*Limitations/Exclusions _____
