

EXAMINATION

Name: _____ Date: _____

Height: _____ Weight: _____ BP: _____ P: _____ R: _____ Vision: Rt. 20 / Left: 20 / _____ Both: 20 / _____
No correction Contacts Glasses (Circle one)

Body Part	Normal	Abnormal findings
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart/Pulses		
Lungs		
Abdomen		
Genitalia (Males only)		
Skin		
Neck		
Back		
Shoulder		
Arm		
Elbow		
Wrist/Hand		
Hip		
Leg		
Knee		
Ankle/Foot		

Urine: Spec. Gravity: _____ **pH:** _____ **Glucose:** _____ **Protein:** _____

Clearance:

___ CLEARED WITHOUT LIMITATIONS

___ CLEARED After completing evaluation/rehabilitation for: _____

___ DISQUALIFIED due to: _____

Other recommendations: _____

Signed: _____ Name/Title of Examiner: _____

Address: _____

Phone: _____ Date of Exam: _____

The following are considered disqualifying factors until medical and parental releases are obtained:

Acute infections, obvious growth problems, diabetes, jaundice, severe visual or hearing loss, pulmonary insufficiency, organic heart disease, hypertension, enlarged liver or spleen, hernia, musculoskeletal deformities or functional loss, history of convulsions or concussion, absence of one kidney or eye or testicle.

ATHLETIC PARTICIPATION FORM

This form must be completed and filed in the school office before the student can participate in athletics

STUDENT _____ **AGE** _____ **GRADE** _____ **DATE** _____

STUDENT'S ADDRESS _____

CITY _____ STATE _____ ZIP _____

PARENT'S NAME _____ PHONE _____ EMERGENCY# _____

FAMILY PHYSICIAN _____ ADDRESS _____

I want to participate in the following sports for the 20__-20__ school year.

MEDICAL HISTORY

(to be completed by parents)

Is there a history of:	Circle One	
A. Birth defects or missing organs	yes	no
B. Known past illness greater than 1 week	yes	no
C. Medical conditions currently under treatment	yes	no
D. Fractures, sprains, or other injury	yes	no
E. Any permanent deformities or disabilities	yes	no
F. Allergies (pollen, dust, food, clothes, Meds.)	yes	no
G. Any surgery	yes	no
H. Any sprains or twisted joints	yes	no
I. Convulsions, seizures, mental disorders	yes	no
J. Loss of consciousness, fainting, knocked out	yes	no
K. Has any family member died suddenly	yes	no
L. Any chest pain or shortness of breath during exercise	yes	no

Explain all "yes" answers: _____

I certify that the information on this form is correct, and I/we agree to abide by the eligibility rules and regulations governing athletics of any and all associations to which my school is a member. I/we also give permission for _____ to practice and play in the athletic events listed above. Furthermore, I/we the undersigned do grant to the officials of the above named school permission for the treatment deemed necessary for any condition arising during the participation in these activities, including medical or surgical treatment recommended by a medical doctor or dentist. I understand that every effort will be made to contact me prior to the treatment, but treatment will not be delayed due to the inability to reach me. I understand that CDS does not provide student medical insurance and all medical expenses resulting from participation in the CDS athletic program are solely my responsibility. I agree to the need for a screening medical examination and certify that the medical history is accurate to the best of my knowledge.

Signature _____ Signature _____

Parent or Guardian

Student

Insurance Company _____ Policy # _____