VICTORY CHRISTIAN ACADEMY

THE CENTER FOR LUTHERAN EDUCATION

Medical Information/Examination

Part 1 Family History

Student's Name: ______________________ Sex: ________ Date of Birth: ______________________

Father's Name: ______________________ Work Phone: ______________ Cell Phone: ______________

Mother's Name: ______________________ Work Phone: ______________ Cell Phone: ______________

Family Doctor: ______________________ Phone: ______________________

Emergency Contact: ______________________ Phone: ______________________

Relationship: ______________________ Phone: ______________________

Part 2 Brief Medical History

Please answer the following questions regarding your son/daughter/ward:

1.	Has had injuries requiring medical attention.	Yes	No
2.	Has had an illness requiring hospitalization.	Yes	No
3.	Is under physician's care at this time.	Yes	No
4.	Has had coughing, wheezing or trouble breathing during or after activity.	Yes	No
	Has had asthma.	Yes	No
	Has had seasonal allergies that require medical treatment.	Yes	No
5.	Are you currently taking any prescription or non-prescription (over the counter) medications or pills or using an inhaler?	Yes	No
	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	Yes	No
6.	Have you ever passed out during or after exercise?	Yes	No
	Have you ever been dizzy during or after exercise?	Yes	No
	Have you ever had chest pain during or after exercise?	Yes	No
	Do you get tired quicker than your friends do during exercise?	Yes	No
	Have you ever had racing of your heart or skipped heartbeats?	Yes	No
	Have you been told that you have a heart murmur?	Yes	No
	Has any family member or relative died of heart problems or of sudden death before age 55?	Yes	No
	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within last month?	Yes	No
	Has a physician ever denied or restricted your participation in sports for any heart problems?	Yes	No
7.	Have you ever had a head injury or concussion?	Yes	No
	Have you ever been knocked out, become unconscious or lost your memory?	Yes	No
	Have you ever had a seizure?	Yes	No
	Do you have frequent or severe headaches?	Yes	No
	Have you ever had numbness or tingling in your arms, hands, legs or feet?	Yes	No
	Have you ever had a stinger, burner or pinched nerve?	Yes	No
8.	Have you ever become ill or felt light headed from exercising in the heat?	Yes	No
9.	Is hearing impaired, has glasses or contact lenses.	Yes	No
10.	Has fixed or removable appliances in mouth?	Yes	No
11.	Is there a reason for this individual to avoid participation on a certain sport?	Yes	No

Please explain if yes response: ______________________

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12. Please bring your son/daughter/ward's **immunization record** to the school office so it can be transferred on to the state form. Contact your doctor or clinic now if you do not have an immunization record.

X ______________________ ______________

Parent/Guardian Signature Date

Part 3 Physical Examination

Student's Name: ____ Sex: ___________ Date of Birth: __________

This section to be completed by a physician or nurse practitioner

Review of Medical History

Pertinent past medical disorders: ____

Current medical disorders: ____

List all medications (both routine and prescription drugs) _______________________________________

Physical Exam

BP ___________ Height _______________ Weight _______________ Vision _______________

Neurological ___________ Head/Neck ____________ Chest/Airway __________

Skin __________ Cardiovascular _________ Abdomen _____________

Genitalia/Hernias ______________ Musculoskeletal _______________ Strength ______________________

Description of abnormalities above: ____

Recommendations:

_______ There are no restrictions or special considerations to participation in the school athletic program. To include Varsity Football and All Varsity Sports.

_______ The following are limitations or special considerations: ___________________________________

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_______ This student should be restricted from participating in high level contact sports at this time.

_______ This student is disqualified from sports until further evaluation.

Physician or Nurse Practitioner Statement/Signature:

I, the undersigned, am licensed to elicit and interpret the medical history, pharmaceutical history, and clinical findings of a complete health assessment for participation in an athletic program or physical education program. I have completed this assessment and recorded all pertinent findings above.

____
Physician, DO or Nurse Practitioner Signature

____
Date of Exam

____
Printed Name

____
License Number

____
Address

____
City, State, Zip