Annapolis Area Christian School

Athletic Pre-Participation Physical Examination

Phone: 410-519-5300 x 3563 Fax: 410-551-0907

Student Name: ________________________________ Street: ___________________________

Date of Birth: _______________ ___________________________

Grade: _____ City, State, Zip: _________________________________

Gender: Male Female Home Phone: ________________________________

In Case of Emergency, Contact:

Name: ____________________________ Relationship: _______________ Phone: _________________

Name: ____________________________ Relationship: _______________ Phone: _________________

Insurance Co. _______________________ Policy #: ______________ Insured: _________________

To be completed by examining physician/nurse practitioner/physician assistant

EXAM DATE__________________

Height________________ Weight_________________ Eyes: R20/___________ L20/___________ Corrected? Y / N

Pupils: Equal/Unequal Pulse:__________ Blood Pressure:___________

MEDICAL	Normal	Abnormal Finding	MUSCULOSKELETAL	Normal	Abnormal Finding
Appearance	_____	__________________	Neck	_____	__________________
Eyes/Ears/Nose/Throat	_____	__________________	Back	_____	__________________
Lymph Nodes	_____	__________________	Shoulder/Arm	_____	__________________
Heart	_____	__________________	Elbow/Forearm	_____	__________________
Pulses	_____	__________________	Wrist/Hand	_____	__________________
Lungs	_____	__________________	Hip/Thigh	_____	__________________
Abdomen	_____	__________________	Knee	_____	__________________
Genitals (Male Only)	_____	__________________	Leg/Ankle	_____	__________________
Skin	_____	__________________	Foot	_____	__________________

CLEARANCE

☐ Cleared for sports participation.

☐ Cleared after completing evaluation/rehabilitation for:

☐ Not cleared for [Sport(s)]: ____________________________________ ________________________

Reason: ____

Recommendation:

I certify that I have on this date examined the above student and I have found no medical reason to disqualify him/her from participating in all supervised athletics and physical education activities with the exception of:____

Name of physician/nurse practitioner/ physician assistant ____

Signature of physician/nurse practitioner/ physician assistant ____

PHYSICIAN STAMP:

***More Information and Parent Signature Needed on Other Side**

COMPLETE THE FOLLOWING INFORMATION.
SIGNATURE REQUIRED BY PARENT/GUARDIAN

Circle "Yes" or "No" and explain "Yes" answers below.

1. Have you had a medical illness or injury since your last exam? Yes / No
   Do you have an ongoing or chronic illness? Yes / No
2. Have you ever had surgery? Yes / No
3. Are you currently taking any prescription or non-prescription medication or using an inhaler? Yes / No
4. Do you have any food or drug allergies? Yes / No
   If yes, do you carry an epinephrine injector? Yes / No
5. Have you ever passed out or been dizzy during exercise? Yes / No
   Have you ever had chest pain during exercise? Yes / No
   Have you had a viral infection within the last month (i.e., mononucleosis)? Yes / No
   Have you had a bacterial infection within the last month (i.e., staphylococcus)? Yes / No
   Has a physician ever denied or restricted your sports participation because of heart problems? Yes / No
6. Do you have any current skin problems (i.e., rash, fungus, hives)? Yes / No
7. Have you ever had a head injury or concussion? Yes / No
   Have you ever been knocked out, become unconscious, or lost memory? Yes / No
   Have you ever had a seizure? Yes / No
   Do you have frequent or severe headaches? Yes / No
   Have you ever had a "stinger", "burner", or pinched nerve? Yes / No
8. Have you ever become ill from exercising in the heat? Yes / No
9. Do you cough, wheeze, or have trouble breathing during exercise? Yes / No
   Do you have asthma? Yes / No
   Do you have seasonal allergies that require medical treatment? Yes / No
10. Do you require special protective or corrective equipment that you use during exercise? Yes / No
11. Do you wear glasses, contacts, or protective eyewear? Yes / No
12. Have you ever had a sprain, strain, fracture, or dislocation? Yes / No
13. Record the dates of your most recent immunizations for:
    Tetanus________________ Hepatitis B___________________ Measles_________________ Chickenpox________________
14. Has a doctor ever told you or a family member that you/they have sickle cell trait or sickle cell disease? Yes / No
15. Have you had any lasting effects as a result of COVID-19? Yes / No

Females Only:

16. At what age was your first menstrual cycle?_____________ When was your last menstrual cycle?____________
    How many menstrual cycles do you have in a year?____________

Explain "Yes" answers here:

Parental Permission/ Waiver/ Medical Authorization

- Permission is hereby given for the student named above to participate in the Annapolis Area Christian School (AACS) athletic program. I certify that my child is in good health and know of no physical conditions, which by participation, would endanger my child's health.
- Consent is given, in the event of illness or injury, for administration of reasonable and prudent first-aid, emergency or professional medical care. I hereby release, discharge, and waive all claims and causes of action against all coaches, teachers, athletic directors, athletic trainers, and staff members of AACS, as well as the school itself from any damages and injuries that might be incurred during any team practice, game, meeting, or during transportation to and from these activities.
- Consent is given for my child to be transported by bus or parent-organized car pool to and from games and off-campus practice facilities when necessary.
- I support the school's administration of team functions including: discipline, scheduling, playing-time in games, and eligibility. I also pledge to observe all guidelines of Christian sportsmanship including respect and courtesy for players, coaches, officials, and other fans.

Parent/Guardian Signature_________________________________ **Date** ______________________

Release of Medical Information Authorization

By signing, I authorize the release of medical information to or between: (a) the Annapolis Area Christian School Athletic Department Sports Medicine Staff (i.e., certified athletic trainer, team physician, and consulting physician), (b) coaching staffs, and (c) the administrative personnel of the Annapolis Area Christian School Athletic Department, concerning injuries or illnesses relating to my child's participation in athletics, past, present, or in the future.

I agree to the release of medical information to help determine the best course of treatment for my child.

Parent/Guardian Signature_________________________________ **Date**