KCAA Kentucky Christian Athletic Association

soul > mind > body

Athletic Participation Physical Examination Form

CORNERSTONE CHRISTIAN ACADEMY
Athletic Department
3850 Frankfort Road
Shelbyville, Kentucky 40065
502-633-4070
502-633-4605 Fax
www.ccaofky.org

I. Athlete Information (Complete by Parent\Student)

Name (Last, First, Initial):		School Year:	Date:
Home Address (Street, City, State, Zip):			
Gender:	Grade:	Date of Birth:	Birth Place:
Parent Name:		Phone:	Email:

II. Medical History (Complete by Parent\Student)

	Yes	No
1. Have you ever been hospitalized?		
2. Have you ever had surgery of any kind?		
3. Are you presently taking any medications or pills?		
4. Do you have any allergies?		
5. Have you ever passed out during exercise?		
6. Have you ever been dizzy during or after exercise?		
7. Have you ever had chest pain during or after exercise?		
8. Have you ever had high blood pressure?		
9. Have you ever been told you have a heart murmur?		
10. Have you ever had racing of your heart?		
11. Has anyone in your family died of heart problems in your family before the age of 50?		
12. Do you have any skin problems?		
13. Have you ever had a head injury?		
14. Have you ever been knocked out or unconscious?		
15. Have you ever had a seizure or suffer from epilepsy?		
16. Have you ever had a stinger, burner, or pinched nerve?		
17. Have you ever had heat related problems?		
18. Have you ever been dizzy or passed out in the heat?		
19. Do you cough heavily, or breathe heavily during activity?		
20. Do you any special equipment?		
21. Have you had any problems with your eyes or vision?		
22. Have you ever sprained/strained, dislocated, fractured, broken, or had repeated swelling or other injuries of any bones?		
23. Are you missing one of any paired organs?		
24. Have you ever been diagnosed with any form of asthma?		
25. Are you using an inhaler for asthma?		
26. Are you diabetic?		
27. Do you administer insulin to yourself?		
28. Are you presently using tobacco in any forms?		
29. Do you have a history of sickle-cell anemia in your family?		
30. Have you had any other medical problems?		
31. Have you had a medical problem or injury within the last year?		
32. Can you swim?		

Participating in which sport(s):

_____ Volleyball

_____ Cross-Country

_____ Soccer

_____ Basketball

_____ Cheerleading

_____ Baseball

_____ Softball

_____ Golf

Other Medical Information:

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Parent Signature _____ Date _____ Student Signature _____ Date _____

ACSI Accredited

AdvancED

III. Physical Examination (Complete by an authorized health care provider)

Patient Name:_____

Height:	Weight:	Blood Pressure: /	Pulse:
Vision (R): 20/	Vision (L): 20/	Vision Both: 20/	Corrected?: Yes / No

	Normal	Abnormal	Comment(s)
Heart			
- Rhythm (Regular/Irregular)			
- Murmur (supine)			
- Murmur (standing)			
Ear\Nose\Throat			
Lungs			
Skin			
Abdominal			
Genitalia			
Musculoskeletal			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			
Dental			
Other			

After having reviewed the data above and the student's medical history, I make the following recommendation(s):	
The Student is cleared for all sports.	Yes / No
The Student is cleared only after additional evaluation for…	
The student is restricted from play the sport(s) of…	
The student is cleared only to play the sport(s) of…	

*I make the following recommendations/restrictions:*_____

I certify I have examined the physical condition of the student and find the said student to by physically fit to practice for and participate in interscholastic athletic events and activities.

_____
Authorized Signature

_____
Date

Provider:	
Address:	
City:	
State\Zip:	
Phone:	