

**CROSSROADS CHRISTIAN SCHOOL
INTERSCHOLASTIC ATHLETIC MEDICAL EXAMINATION**

**THIS MEDICAL EXAMINATION AND FORM MUST BE COMPLETED ANNUALLY
AND BE ON FILE PRIOR TO ANY ATHLETIC PRACTICE OR COMPETITION.**

STUDENT

SCHOOL _____ GRADE _____ DATE _____
ADDRESS OF STUDENT _____
CITY _____ STATE _____
ZIP _____
PARENTS' NAME _____
TELEPHONE _____
FAMILY PHYSICIAN _____
ADDRESS _____

I hereby apply for permission to participate in the following interscholastic sports:

I certify that the information contained in this application is correct, and I agree to abide by the eligibility rules and regulations of the State Association.

SIGNATURE OF STUDENT _____

MEDICAL HISTORY

(To be completed by parents)

STUDENT _____ **AGE** _____ **DOB** _____

Is there a known history of:

- A. Birth deformities (one eye, one kidney, etc.)? Yes _____ No _____
- B. Known past illness of more than one week's duration? Yes _____ No _____
- C. Medical conditions currently under treatment? Yes _____ No _____
- D. Fractures or other disabling injuries? Yes _____ No _____
- E. Any permanent deformity or disability? Yes _____ No _____
- F. Allergy (drugs, food, clothing, etc.)? Yes _____ No _____
- G. Mental disorder or convulsions? Yes _____ No _____

Explain any above questions answered "yes"

PARENTAL PERMISSION

As parent or legal guardian of _____, I hereby give my consent for (him/her) to practice and play in the athletic events listed above.

I also grant permission for treatment deemed necessary for a condition arising during participation in these activities, including medical or surgical treatment recommended by a medical doctor. I understand that every effort will be made to contact me prior to treatment.

I agree to the need for a screening medical examination and certify that the medical history below is accurate to the best of my knowledge.

SIGNATURE OF PARENT _____

EXAMINATION

Height _____ Weight _____ Blood Pressure _____

NORMAL (ABNORMAL - DESCRIBE ABNORMALITIES)

1. _____ Eyes
2. _____ ENT
3. _____ Heart
4. _____ Lungs
5. _____ Abdomen
6. _____ Genitalia (males only)
7. _____ Musculoskeletal
8. _____ Neurological
9. _____ Skin

LABORATORY

Urinalysis:

Other (where indicated):

I certify that I have examined this student and find him medically (qualified, not qualified) to compete in the interscholastic sports listed above.

Licensed to practice medicine in N. C.? Yes _____ No _____

PHYSICIAN'S SIGNATURE

Address _____ Date _____

If student not qualified, list reasons for disqualification:
