



# 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 Information (to be completed by student/parents):

Name of Student \_\_\_\_\_ Date: \_\_\_\_\_ Grade: \_\_\_\_\_

Student's Address: \_\_\_\_\_  
*Street City State Zip*

Parent's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Address: \_\_\_\_\_  
*Street City State Zip*

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.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

### Medical History (to be completed by parents):

Student Date of Birth: \_\_\_\_\_ Current Age of Student: \_\_\_\_\_

Is there a known history of any of the following?

1. Birth deformities (one eye, one kidney, etc.)?  Yes  No
2. Known past illness of more than one week's duration?  Yes  No
3. Medical conditions currently under treatment?  Yes  No
4. Fractures or other disabling injuries?  Yes  No
5. Any permanent deformity or disability?  Yes  No
6. Allergy (drugs, food, clothing, etc.)?  Yes  No
7. Mental disorder or convulsions?  Yes  No

Explain any above questions answered with a "Yes":

\_\_\_\_\_

### Parental Permission:

As parent or legal guardian of \_\_\_\_\_, I hereby give my consent for him/her to practice and play in the athletics 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.

Parent Signature \_\_\_\_\_ Telephone Number \_\_\_\_\_ Date \_\_\_\_\_



# Examination for

\_\_\_\_\_  
*Student Name*

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

### Normal?

- \_\_\_\_\_ 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)?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Physician's Certification:

I certify that I have examined this student and find him/her medically

- Qualified
- Not qualified

to compete in the interscholastic sport(s) listed above.

If student is not qualified, list reasons for disqualifications:

\_\_\_\_\_

\_\_\_\_\_

Are you licensed to practice medicine in North Carolina?  Yes  No

\_\_\_\_\_  
*Physician Name (print)*

\_\_\_\_\_  
*Physician Signature & DEA#*

\_\_\_\_\_  
*Date*