Maranatha Christian School
PRE-PARTICIPATION HEALTH ASSESSMENT

Name: _____Date of Birth: _____

Address: _____

Person to notify in an emergency: _____ Phone: _____

Physician: _____Phone: _____

School: _____ Phone: _____

History to be completed by student assisted by parents.

	Yes (Check One)	No (Check One)	
1			Did your grandparents, parents, brothers/sisters under age of 50 have heart problems, or high blood pressure?
			Have you ever had or do you have:
2			Heart murmer, high blood pressure, extra heart beats or a heart abnormality?
3			Need for using medications? Name:_____
4			Concussion or problems "passing out"?
5			Medicine allergy? Name:_____
6			Any illness, injury, or condition that lasted more than a week?
7			Hospitalization or surgery? Why?_____
8			Dental appliance?
9			Contacts or glasses?
10			To stop running around a 1/4 mile track twice?
11			An illness or injury that caused you to miss a game or practice?
12			Congenital absence or loss of function of one organ (eye, ear, kidney, etc.)?
13			Headaches (frequent)?
14			Asthma?
15			Convulsions (Seizures)?_____ How many?_____
16			Neck or spine injury?_____
17			Broken bones?_____
18			Sprains or dislocations?_____
19			Date of last tetanus shot (within last 10 years)_____
20			FEMALES: Have you had a period in the last 6 months? How many?_____
21			FEMALES: Do menstrual cramps keep you from regular activities?

Parental Permission

I give my permission for _____ to be a part of the athletic program for the 20 _____- 20 ____ school year. I also grant permission for treatment deemed necessary for a condition arising during participation in these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers, coaches, doctors or those under their direction who are a part of the athletic prevention or treatment, to have access to necessary medical information. I know that the risk of injury/ward comes with participation in sports and during travel to and from play and practice. My signature indicates that to the best of my knowledge, my answers to the above questions are complete and correct.

_____ _____

Parent's Signature Parent's Signature

Date: _____ Date: _____

Maranatha Christian School
Medical Examination Form

Please Print

_____ _____
Last Name First Name Initial Date of Birth

Gender: ____M ____F Age: _____ Grade:_____

PHYSICAL EXAM- To be completed By Physician
Height_____ Weight_____ Pulse_____ Blood Pressure_____

	Normal	Abnormal Findings	Initials
1. Eyes (vision)			
2. Ears, Nose, Throat			
3. Mouth & Cheek			
4. Neck			
5. Cardiovascular			
6. Abdomen			
7. Chest & Lungs			
8. Skin			
9. Genitalia-Hernia male)			
10.Musculoskeletal: ROM, strength, etc.			
❑ Neck			
❑ Spine			
❑ Shoulders			
❑ Arms/Hands			
❑ Hips			
❑ Thighs			
❑ Knees			
❑ Ankles			
11. Neuromuscular			

____Cleared without restrictions
____Cleared, with recommendations for further evaluation or treatment for _____
_____
_____Not Cleared ____All Sports ____Certain Sports: _____

I certify that I have examined this athlete on this date and found him/her medically qualified to participate in sports. I also certify here that I am a licensed physician.

Physician's Signature:_____ Date:_____
Physician's Address:_____