

OPEN BIBLE CHRISTIAN ACADEMY

13 Open Bible Way Kingsville, Maryland 21087
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PART 1 - Medical Evaluation of Student for Participation in Interschool Sports

To be completed by Parent or Guardian and submitted to the examining physician before he examines the student.

Name of Student _____ Date of Birth _____ Grade _____ School _____

Parent _____ Home Address _____ Home Phone _____

Personal Health of Student	(check correct reply)	YES	NO	(check correct reply)	YES	NO
1. Has had injuries or accidents requiring medical attention.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Has had tetanus toxoid and booster inoculation.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Has had a surgical operation.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of last booster____/____/____		
3. Has been in a hospital.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Has seen a dentist within the past 6 months.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Has had sickness lasting longer than one week.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. To my knowledge the paired organs that follow are present and healthy:		
5. Takes medicine now or regularly.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Has a condition now under a physician's care.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ears (hearing).....	<input type="checkbox"/>	<input type="checkbox"/>
7. Has a defect in hearing or eyesight..... (wears glasses, contact lenses)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Is there any reason this student should not take part in any sport?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidneys.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Has had complete poliomyelitis immunization by injections (Salk) or vaccine by mouth (Sabin).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Testicles or ovaries.....	<input type="checkbox"/>	<input type="checkbox"/>
				Arms/legs.....	<input type="checkbox"/>	<input type="checkbox"/>
				Fingers/toes.....	<input type="checkbox"/>	<input type="checkbox"/>

If you answered "YES" to any of the above questions, explain here with names and dates: _____

If you answered "NO" to any of the above questions, explain here with names and dates: _____

* I hereby give my consent for the above secondary school student to engage in interschool sports activities as a representative of his school, except those activities crossed out by the examining physician on the reverse side of this form. I also give my consent for the above student to accompany the team as a member for its "away" games and contests.

* I give my permission for the physician to complete Part 2 for confidential use in meeting my child's health and education needs in school.

Signature of Parent: _____

Date: _____

PART 2 - Medical Evaluation of Student for Participation in Inter-school Sports

To be completed by a physician or under his supervision.

Name of Student _____ Grade _____

Significant past illnesses or injuries _____

PHYSICIAN'S EXAMINATION: (Circle and explain abnormal findings.)

Height _____ Weight _____ Blood Pressure _____ Pulse Rate _____

Eyes _____ Visual Acuity R ____ / ____ : ____ L ____ / ____

Ears _____ Hearing R ____ / ____ : ____ L ____ / ____

Nose (deformities) _____ Oropharynx _____

Teeth (cavities, dentures, braces) _____ Respiratory _____

Breasts (M & F) _____ Cardiovascular (pedal pulses) _____

Abdomen (hernia, spleen, liver) _____ Genitalia and anus _____

Neuromuscular _____ Skin _____

Spine (cervical, thoracic, lumbar) _____

Extremities (special attention to knees, ankles) _____

Additional explanation of abnormal findings _____

Laboratory:

Urinalysis: Protein _____

Sugar _____

Other _____

*Tuberculin Test _____

OR

*Chest X-ray (Result/Date) _____

*Other Laboratory Tests _____

**if ordered by physician*

I have this date personally examined this pupil, reviewed the history and other data recorded on both sides of this form, and find this pupil physically able to compete in the supervised activities listed below which are **not crossed out**:

Baseball
Basketball
Cross Country

Field Hockey
Football
Golf

Gymnastics
Lacrosse
Soccer

Softball
Swimming
Tennis

Track
Volleyball
Wrestling (Minimum weight for wrestling)
Other _____

Physician's Signature _____, M.D. Address: _____

Physician's Name Printed: _____

Date of Examination: _____ Phone: _____