GRACE CHRISTIAN SCHOOL

MEDICAL HISTORY

To be completed and signed in three places by parent or guardian or 18-year-old

A current year physical is one given on or after April 15 of the previous school year.

NAME: Last	First	Sex	Grade	Age
ADDRESS: Street	City	Zip		

Father's/Guardian's Name	Work Phone	Mother's/Guardian's Name	Work Phone
Family Doctor	Office Phone	Home Phone	Date of Birth

INSURANCE STATEMENT

Our son/daughter will comply with the specific insurance regulations of the school district.

•Family Insurance Company: ____________________ Contract #: ____________

•**Signature of Parent or Guardian or 18-Year-Old:** X ____________________

HISTORY	YES	NO	HISTORY	YES	NO	HISTORY	YES	NO
Have you ever had:			**Have you ever had:**			**Do you now have:**		
Fainting			Kidney Disease			Painful Joints		
Diphtheria			Tuberculosis			Backaches		
Scarlet Fever			Jaundice			Pounding of Heart		
Rheumatism			Sickle-Cell Anemia			Shortness of Breath		
Rupture						Frequent Urination		
Rheumatic Fever			**Do you now have:**			Cough		
Poliomyelitis			Blurred Vision			Nosebleeds		
Pneumonia			Headaches			Frequent Sore Throats		
Asthma			Fainting			Stomach Pains		
Diabetes			Convulsions					
Heart Disease			Blackouts					

PHYSICAL EXAMINATION

To be completed by the examining MD, DO, Physician's Assistant or Nurse Practitioner
(Categories may be added or deleted, check appropriate column.)

SYSTEM	NORMAL	ABNORMAL	SYSTEM	NORMAL	ABNORMAL
Urinalysis			Thyroid		
Vision			Chest		
Blood Pressure			Lungs		
Pulse Rate			Heart		
Ears			Abdomen		
Nose			Hernia		
Throat			Genitalia/Testicular Exam		
Teeth-Cavities			Neurologic		
Orthopedic			Muscular		

RECOMMENDATIONS: ____________________

I certify that I have examined the above student and recommend him/her as being able to comepete in supervised athletic activities not crossed out below.

Baseball-Basketball-Competitive Cheer-Cross Country-Football-Golf-Gymnastics-Ice Hockey-Skiing- Soccer Softball-Swimming-Tennis-Track-Volleyball-Wrestling

A CURRENT YEAR PHYSICAL IS ON GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR.

SIGNATURE OF EXAMINER: X ____________ ☐ **MD** ☐ **DO** ☐ **PA** ☐ **NP**

PRINTED NAME OF EXAMINER: ____________ DATE: ____________

MEDICAL TREATMENT CONSENT

To be completed by Parent or Guardian or 18 yr. old

I, ____________________, (an 18-year-old) the parent or guradian of ____________________ recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then-existing circumstances and to assume the expenses of such care.

SIGNATURE OF PARENT OR GUARDIAN OR 18-YEAR-OLD **DATE:**

X