Legacy Christian Academy

2255 Horal • San Antonio, Texas 78227 • Phone 210-674-0490 • Fax 210-674-3615
www.legacychristianacademysa.org

Grade Entering:

School Year:

Received by:

Health & Sports Physical

STUDENT INFORMATION____
LAST FIRST MIDDLE PREFERRED NAME

____
STREET APARTMENT

____
CITY STATE ZIP PHONE

_____/______/______ ____________
DATE OF BIRTH AGE ☐ MALE ☐ FEMALE

PARENT/GUARDIAN____
LAST FIRST MI PREFERRED NAME

Home Phone (______) _______________Cell Phone (______) _________________Business Phone (______) __________________

EMERGENCY CONTACT ____
LAST FIRST MI PREFERRED NAME

Home Phone (______) ________________Cell Phone (______) ________________Business Phone (______) __________________

EMERGENCY INFORMATION

Insurance Company_______________________ Subscriber Name_________________________ Policy #_____________________
SPONSOR SPONSOR'S #

Hospital of Choice________________________________ Family Physician_______________________ Phone__________________

Allergies____ Medications ____

MEDICAL HISTORY:

☐ YES ☐NO Has the student been hospitalized during the past 12 months
☐ YES ☐NO Has the student had any injuries requiring medical attention during the past 12 months?
☐ YES ☐NO Has the student been ill lasting more than one week during the past 12 months?
☐ YES ☐NO Is the student currently taking prescribed medication and/or under a physician's care?
☐ YES ☐NO Are you aware of any reason(s) this student should be limited or kept from participating in any athletic activity?
☐ YES ☐NO Has the student ever passed out, been dizzy or had chest pain during or after exercise?
☐ YES ☐NO Has student ever had high blood pressure?
☐ YES ☐NO Has student ever experienced heart palpitations, skipped heartbeats or been told of having a heart murmur?
☐ YES ☐NO Has any family member or relative died of heart problems or of sudden death before age 50?
☐ YES ☐NO Has a physician ever denied or restricted this student from participating in sports due to heart problems?
☐ YES ☐NO Has the student ever had a concussion, been knocked out, experienced memory loss, and/or had a seizure?
☐ YES ☐NO Does the student have asthma?
☐ YES ☐NO Does the student use an inhaler?
☐ YES ☐NO Does the student cough, wheeze, or have trouble breathing during or after activity?
☐ YES ☐NO Does the student have any allergies (pollen, medicine, food, insects, etc.)?
☐ YES ☐NO Is the student missing any paired organs (eye, kidney, etc.)?
☐ YES ☐NO Has the student ever had a sprain, strain, or swelling after an injury?
☐ YES ☐NO Has the student ever broken or fractured any bones or dislocated any joints?
☐ YES ☐NO Has the student ever had any problems with pain or swelling in muscles, tendons, bones, or joints?
☐ YES ☐NO Does the student use protective or corrective appliances such as glasses, contact lenses, braces, retainer, etc.?
☐ YES ☐NO Has the student ever been diagnosed with diabetes?
☐ YES ☐NO Has the student ever been diagnosed with any type of blood disorder?
☐ YES ☐NO Has the student ever had the chicken pox? If yes, indicate month/year. _____/_____
What year was the last tetanus booster given? __________

Please explain any "yes" answers from above: ____

____

____

FAMILY MEDICAL HISTORY: (check all that apply)

☐ Diabetes ☐Heart Disease/Disorder ☐ Seizure Disorder ☐Neurological Disorder
☐ Blood Disorder ☐Kidney Disorder ☐ Hypertension ☐Other: __________________________

CONSENT TO PARTICIPATE: I/We, as legal guardian(s), give our permission for our child, ____, to participate in organized athletics through Legacy Christian Academy, except for ______________________, realizing that such activity involves the potential for injury which is inherent in all activities. I/We acknowledge that even with the best coaching, use of protective equipment and strict observance of rules, injuries are still a possibility. On rare occasions, these injuries can be so severe as to result in total disability, paralysis, or death.

CONSENT FOR EMERGENCY MEDICAL TREATMENT: If in the judgment of any representative of the school or church, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given to said student by a physician, trainer, nurse, school or church representative, and I do hereby agree to indemnify and save harmless the school, church and any school representative from any claim by any person whosoever on account of such care and treatment of said student . Also, if there are any changes to any information on this form (including physician exam record below) between this date and the last day this school year. I/We, as legal guardians, agree to immediately submit changes in writing to LCA officials.

I/We, as legal guardians, acknowledge that I/we have read and understand the content of this Health and Sports Physical Form in its entirety, and have completed the medical history information on the front side of this sheet. I/We further understand that no sports participation will be allowed until this form is completed and returned to school office.

_______________________________________ _____________

Parent/Guardian Signature **Date**

VISION SCREENING RECORD-PHYSICIAN USE ONLY

REQUIRED FOR: students in K4, K5, 1, 3, 5, 7 and all new students K4-12

Vision
Right 20/
Left 20/
Results: Pass Fail

________________________ ___________

Physician's Signature Date

HEARING SCREENING RECORD-PHYSICIAN USE ONLY

REQUIRED FOR: students in K4, K5, 1, 3, 5, 7 and all new students K4-12

Hearing						
Hz	250	500	1000	2000	4000	6000
R						
L						
Results: Pass Fail						

________________________ ___________

Physician's Signature Date

SPINAL SCREENING RECORD – PHYSICIAN USE ONLY

REQUIRED FOR: GIRLS in grades 5 and 7; BOYS in grade 8

Results: Pass Fail	____ Physician's Signature	___________________________ Date

PHYSICIAN'S EXAMINATION RECORD-PHYSICIAN USE ONLY

REQUIRED FOR: students in K4, K5, 1, 3, 5, 7 and all sports participants K4-12

	N	Abnormal		N	Abnormal	Joint Function	N	Abnormal		N	Abnormal
Eyes			Chest			Shoulders/Arms			General Body Build		
Ears			Heart			Elbows/Forearms			Skin		
Nose			Lungs			Wrists/Hands					
Teeth			Abdomen			Hips/Thighs					
Throat			Spleen			Knees			Neurological		
Neck			Liver			Legs/Ankles			Hernia		
Lymph Nodes			Spine			Feet			Genitalia (male only)		

Height: Weight: Pulse: Blood Pressure: UA: Sugar: Albumin:

Description of abnormal findings (if any):

____

PHYSICAL ACTIVITY:

- ☐ **Cleared without restrictions**
- ☐ **Cleared with restrictions**____
- ☐ **Not Cleared** ____

_______________________________________ __________________________

Physician's Signature **Date**

Physician's Printed Name: ____ **Phone #:** ________________________

Address/City/Zip: ____

LCA requires a copy of student's most current IMMUNIZATION RECORD.

Please update your child's immunizations and submit a copy of the record to the school office.