HICKORY GROVE CHRISTIAN SCHOOL

PHYSICAL ASSESSMENT FORM

"To Know Christ and To Make Him Known Through Christian Education"

THIS FORM MUST BE COMPLETED FOR STUDENTS PARTICIPATING IN ANY ATHLETIC SPORT AT HGCS.

It is the responsibility of the student/parent to keep the original form completed by the physician and are responsible for providing all copies.

Student Information: _____ _____ ___/___/___
Name as it appears on birth certificate *Grade* *Date of birth*

Residence: _____ _____
Street address *City/ZIP*

Father/Mother/Guardian: _____

_____
Insurance Company *Policy Number*

_____
Primary Phone Number *Secondary Phone Number*

IN THE EVENT OF AN EMERGENCY AND I AM UNABLE TO BE CONTACTED, PLEASE CONTACT THE FOLLOWING:

_____
Name *Relationship to named student* *Phone Number*

EMERGENCY MEDICAL TREATMENT PERMISSION AND INFORMATION

I hereby authorize the school to obtain, through a physician of its own choice, any emergency care that may become reasonably necessary for my child in the event of an emergency and immediate action is required or if no one listed above can be reached. I or the insurance company providing coverage for above named student guarantee payment of all charges incurred for medical treatment.

Allergies and/or special medical problems (asthma, diabetes, etc.) _____

Past history of any medical problems or surgeries _____

Family Physician _____ Phone _____

Hospital Preference _____

Parent Signature _____

STUDENT PARTICIPATION PERMISSION

Participation in competitive athletics may result in severe injury, including paralysis and death. Improvement in equipment, medical treatment and physical conditioning, as well as rule changes, have reduced these risks, but it is impossible to totally eliminate such occurrences from athletics.

Except for those activities crossed out below, I hereby give my consent for the above-named student to represent HGCS in band, flag corps, or athletic activities, including travel for local or out-of-town trips:

Baseball	Cross Country/Track	Football	Soccer	Tennis	Volleyball
Basketball	Cheerleading	Golf	Softball	Swimming	Weightlifting

STATEMENT: I certify that all the information in this application is correct and I agree to abide by the eligibility rules and regulations governing athletics as set forth by HGCS.

Legal Signature of Guardian _____ Home/Work Telephone _____ Relationship to Student _____ Date _____

ATHLETE'S HISTORY QUESTIONNAIRE

Explain "Yes" answers on top of next page:	Yes	No
1. Has your child ever been hospitalized?	❑	❑
2. Has your child ever had surgery?	❑	❑
3. Are you presently taking any medications or pills?	❑	❑
4. Do you have any allergies (medicine, bees or other stinging insects, latex)?	❑	❑
5. Has your child ever passed out DURING exercise, emotion or startle?	❑	❑
6. Has your child ever fainted or passed out AFTER exercise?	❑	❑
7. Has your child had extreme fatigue associated with exercise (different from other children)?	❑	❑
8. Has your child ever had unusual or extreme shortness of breath during exercise?	❑	❑
9. Has your child ever been dizzy during or after exercise?	❑	❑
10. Has your child ever had chest pain during or after exercise?	❑	❑
11. Has your child ever been diagnosed with an unexplained seizure disorder or exercise-induced asthma?	❑	❑
12. Has a doctor ever told you that your child has high blood pressure?	❑	❑
13. Has a doctor ever told you that your child has high cholesterol?	❑	❑
14. Has a doctor ever told you that your child has a heart infection?	❑	❑
15. Has a doctor ever ordered a test for your child's heart?	❑	❑
16. Has a doctor ever told your child has a heart murmur?	❑	❑
17. Has your child ever had discomfort, pain, or pressure in his chest during exercise or complained of his heart "racing"or "skipping beats"?	❑	❑
18 Do you have any skin problems (itching, rashes, acne)?	❑	❑
19. Have you ever had a head injury?	❑	❑
20. Have you ever been knocked out or unconscious?	❑	❑
21. Have you ever had a seizure?	❑	❑
22. Have you ever had a stinger, burner or pinched nerve?	❑	❑
23. Have you ever had heat or muscle cramps?	❑	❑
24. Have you ever been dizzy or passed out in the heat?	❑	❑
25. Do you have trouble breathing or do you cough during or after activity?	❑	❑
26. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guard, etc.)?	❑	❑
27. Have you had any problems with your eyes or vision?	❑	❑
28. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury of any bones or joints? ❑ Head ❑ Shoulder ❑ Thigh ❑ Neck ❑ Elbow ❑ Knee ❑ Chest ❑ Hip ❑ Forearm ❑ Shin/calf ❑ Back ❑ Wrist ❑ Ankle ❑ Hand ❑ Foot	❑	❑
29. Have you ever had an eating disorder, or do you have any concerns about your eating habits or weight?	❑	❑
30. Do you have any chronic medical illnesses (diabetes, asthma, kidney problems, etc.)?	❑	❑
31. Have you had a medical problem or injury since your last evaluation?	❑	❑
32. Do you take any supplements? If so, list	❑	❑
33. When was your last tetanus shot?	❑	❑
34. When was your last measles immunization?	❑	❑

FAMILY HISTORY

Has any family member had a sudden, unexpected , unexplained death before age 50 (including from sudden infant death syndrome [SIDS], car accident, drowning?	❑	❑
Has anyone in your family died suddenly of heart problems before age 50?	❑	❑
Has any family member had unexplained fainting or seizures?	❑	❑
Do any relatives have a heart condition, such as: Hypertrophic cardiomyopathy (Enlarged Heart)	❑	❑
Dilated cardiomyopathy	❑	❑
Aortic rupture or Marfan syndrome or Ehlers-Danlos syndrome	❑	❑
Coronary artery atherosclerotic disease (heart attack, age 50 yrs. or younger	❑	❑
Arrhythmogenic right ventricular cardiomyopathy	❑	❑
Long QT syndrome	❑	❑
Short QT syndrome	❑	❑
Brugada syndrome	❑	❑
Catecholaminergic ventricular tachycardia	❑	❑
Primary pulmonary hypertension	❑	❑
Pacemaker or implanted cardiac defibrillator	❑	❑
Congenital deafness (deaf at birth)	❑	❑

Explain all "Yes" answers on History Section (previous page): _____

_____

_____

_____

(THIS SECTION TO BE COMPLETED BY PHYSICIAN ONLY)
HEALTH EXAMINATION

Student's Name _____

Age _____ Height _____ Weight _____ Blood Pressure _____

List significant past illness or injury _____

_____

Eyes _____ R/20/ L/20/ Hearing _____ R /15 L /15

Cardiovascular _____ Respiratory _____

Spleen _____ Liver _____

Musculoskeletal _____ Hernia _____

Neurological _____ Skin _____

Urinalysis _____ Genitalia (males) _____

Comments: _____

I have examined this student and find him/her physically able to compete in the following supervised activities NOT CROSSED OUT below:

Baseball	Soccer	Softball	Basketball	Football
Tennis	Cross Country	Volleyball	Cheerleading	Golf
Swimming	Weightlifting	Track		

Actual date of physical _____

Signature of Examining Physician _____

Address of Physician _____

Licensed to Practice Medicine in North Carolina? Yes ❑ No ❑

This form will be used and filed by the Athletic Trainer.

Hickory Grove Christian School Athletic Department
7200 E. WT Harris Boulevard, Charlotte, NC 28215
Athletic Office: 704-531-4038
FAX: 704-531-3484