Physician's Certificate
For
Participation in School Sports

Name of Student: ______________________ School Year: ______________
Height: ________ Weight: _________ Sex: ______ Age: ______ Grade: ________
Sports to Participate in: ____

Eyes ____________________
Ears ____________________
Nose ____________________
Throat ____________________
Teeth ____________________
Skin ____________________
Lymphatics ____________________
Heart ____________________
Lungs ____________________
Abdomen ____________________
Genitalia/hernia ____________________

Peripheral pulses ____________________
Cervical spine/neck ____________________
Back ____________________
Shoulders ____________________
Arm/elbow/wrist/hand ____________________
Knees/hips ____________________
Ankles/feet ____________________
BP ____________________
Pulse (rest) ____________________
(exercise) ____________________
Urinalysis ____________________

Please List:
Physical Limitations: ____

Allergies: ____

Is student presently taking medication? ____________ If so, what type? ______________
Significant past illness or injury: ____

Comments, Special Problems, etc.: ____

I certify that ______________________________ (name of student) was examined and is physically fit to actively participate in after-school sports programs at Grace Christian School

Physician Signature: ______________________________, M.D. Date: ____________

Physician Name (please print): ______________________________
Address: ______________________________
City/State/Zip Code: ______________________________
Telephone: ______________________________

Medical History

This form should be completed by patient. The physician will review the answers with you.

	YES	NO
1. Have you ever had any of the following?	______	______
heart murmur	______	______
high blood pressure	______	______
other heart problems	______	______
broken bones	______	______
weak joints – ankles, knees	______	______
concussion	______	______
operation	______	______
seizures or epilepsy	______	______
2. Have you ever fainted or passed out?	______	______
3. Have you ever been knocked out?	______	______
4. Have you ever been hospitalized?	______	______
5. Have you ever had to stop exercising because of chest pain or shortness of breath?	______	______
6. Have you ever had significant allergies?	______	______
hay fever	______	______
asthma	______	______
bee stings	______	______
foods	______	______
medications	______	______
7. Do you take any medicine regularly?	______	______
8. Have you had any illness lasting a week or more?	______	______
9. Have you had any blood disorders?	______	______
10. Has any family member had a heart attack, heart problems or other sudden death before age 50?	______	______
11. Do you wear contact lenses; eye glasses or dental appliances?	______	______
12. Do you have any missing or non-functioning organs such as testes, eye, kidney, etc…	______	______
13. Menstrual History:		
(a) What age started/stopped?	______	______
(b) Do you have any menstrual problems?	______	______

14. DATE OF LAST TETANUS IMMUNIZATION____

Please explain any yes answers from above: ____

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I certify that the above information is true and correct.

____ Date: ______________________

Signature of Patient