CHRISTIAN HIGH SCHOOL PHYSICAL FORM

(PLEASE PRINT)

Athlete's Name: _____ Birth Date: _____ Home Phone: _____
Address: _____
Father's Cell/Office: _____ Mother's Cell/Office: _____
Family Physician: _____ Phone: _____
Medical Insurance Carrier: _____ Policy#: _____
Customer Service Phone Number: _____

Has Athlete had any of the following:	(Circle One)	Explain "Yes" Answers: (Use back if more space is needed)
1. Any injuries to the head, neck, bones or joints?	Yes No	
2. Any other injury requiring medical attention?	Yes No	
3. Any illness lasting more than a week?	Yes No	
4. Any seizures or episodes of unconsciousness?	Yes No	
5. Heart trouble, murmur or high blood pressure?	Yes No	
5. Wear glasses or contacts?	Yes No	
6. Any allergies to medications?	Yes No	
7. Any surgeries or hospitalization?	Yes No	
8. Any serious infectious disease?	Yes No	
9. Currently under a Doctor's care?	Yes No	
10. Currently taking any medications?	Yes No	
11. Any dental problems?	Yes No	
12. Any reason why student should not participate?	Yes No	

Parent's/Legal Guardian's Signature: _____ Date: _____

PHYSICAL EXAMINATION: (to be completed by Physician only)

I certify that the above-named individual's health history form has been examined and that a physical examination pertaining to disqualifying abnormalities of general physical qualifications, dental, respiratory system, cardiovascular system (except blood pressure), gastrointestinal system, musculoskeletal system and genitourinary system has been performed by me/or my colleagues on this date .
The following abnormalities were detected: (If none, then print "None") (Use back side if more space is required)

_____

_____

_____

In my opinion, he/she is qualified to participate in the high school athletic program.
Circle One: YES NO

Attach Doctor's Business Card or Official Seal/Stamp here (Required)

Physician's Signature: _____
Date: _____ Phone: _____
Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____