CHAMPIONS CHRISTIAN ACADEMY
ATHLETIC/PE HEALTH SURVEY AND CONSENT FORM

This form was developed in part by the State of Texas' UIL. It must be completed annually by a parent or guardian and student for the student to participate in activities. These questions are designed to determine if the student had any condition which would make it hazardous to participate in athletics or PE.

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Student's Name: _____ Gender_____ Age _____ DOB_____
Address: _____Phone: _____
Physician/PA/NP Name: _____Phone: _____
Emergency Contact: _____Phone: _____

Please answer all questions, add any comments, and circle any questions you don't know the answer to.

1. Have you had a medical illness or injury since your last check-up or physical? ___yes ___no
2. Have you been hospitalized overnight in the past year, or have you ever had surgery? ___yes ___no
If yes, explain _____
3. Have you ever had prior testing for the heart ordered by a physician? ___yes ___no
4. Have you ever passed out during or after exercise? ___yes ___no
5. Have you ever had chest pain during or after exercise? Do you get tired more quickly than your friends do during exercise? ___yes ___no
6. Have you ever had episodes when your heart raced or skipped heartbeats? ___yes ___no
7. Have you had high blood pressure or high cholesterol? ___yes ___no
8. Have you ever been told you have a heart murmur? ___yes ___no
9. Has any relative died of heart problems or of sudden unexpected death before age 50? ___yes ___no
If yes, explain _____
10. Has any family member been diagnosed with an enlarged heart, Dilated cardiomyopathy, hypertrophic cardiomyopathy, long QT syndrome or other ion channelopathy, Bragada syndrome, etc., Marfan's syndrome, or abnormal heart rhythm? ___yes ___no
11. Have you had a viral infection such as myocarditis or mononucleosis within the last month? ___yes ___no
12. Has a physician ever denied or restricted your participation in activities for any heart problems? ___yes ___no
13. Have you ever had a head injury or concussion? ___yes ___no
14. Have you ever been knocked out, become unconscious, or lost your memory? ___yes ___no If yes, please explain how many times, date of occurrence, and how severe: _____
_____
15. Have you ever had a seizure? ___yes ___no
16. Do you have frequent or severe headaches? ___yes ___no
17. Have you ever had numbness or tingling in your arms, hands, legs, or feet? ___yes ___no
18. Have you ever had a stinger, burner, or pinched nerve? ___yes ___no
19. Are you missing any paired organs? ___yes ___no
20. Are you currently under a doctor's care for treatment of an illness or injury? ___yes ___no
If yes, explain _____
21. Are you currently taking any prescription or non-prescription medication or using an inhaler? ___yes ___no
If yes, explain _____
22. Do you have any allergies such as to pollen, medicine, food, or stinging insects? ___yes ___no
23. Have you ever been dizzy during or after exercise? ___yes ___no
24. Do you have any skin problems such as, itching, rashes, acne, warts, fungus, or blisters? ___yes ___no
25. Have you ever become ill from exercising in the heat? ___yes ___no
26. Have you had any problems with your eyes or vision? ___yes ___no
27. Have you ever gotten unexpectedly short of breath with exercise? ___yes ___no
28. Do you have asthma? ___yes ___no

29. Have you ever had a sprain, strain, or swelling after injury? ___yes ___no
30. Have you broken or fractured any bones or dislocated any joints? ___yes ___no
31. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?
If yes, explain _____
32. Please list areas of concern you feel school staff should be aware of: _____
_____
_____
33. An electrocardiogram (ECG) is not required. You may choose to obtain an ECG for the student for additional cardiac screening. I have read and understand the information about cardiac screening. I understand it is the responsibility of my family to schedule and pay for such ECG.

Any Yes answer to the above questions may require further medical evaluation which may include a physical examination. The Athletic Director will determine if a further physical examination is required. If needed, the exam and written clearance must come from a physician, physician assistant, chiropractor, or nurse practitioner.

AGREEMENT:

MY CHILD HAS NO KNOWN HEALTH PROBLEMS OR CONCERNS OTHER THAN THOSE LISTED ABOVE. MY CHILD HAS PERMISSION TO PARTICIPATE IN PE AND/OR ATHLETICS WITHOUT RESTRICTION. I acknowledge, appreciate, and agree that the risks of injury and/or illness from the activities involved in PE and/or Athletics are significant, and I knowingly and freely assume all such risks for my child, both known and unknown, and assume full responsibility for my child's participation, knowing that supervision and rules are in place to reduce said risks, but also knowing that the risks still exist.

I GIVE PERMISSION FOR MY CHILD TO RECEIVE FIRST AID FOR MINOR CUTS/SCRAPES/SKIN IRRITATIONS UNDER THE SUPERVISION OF SCHOOL STAFF. THIS WOULD INCLUDE THE USE OF OVER-THE-COUNTER OINTMENTS/CREAMS PER PACKAGE INSTRUCTIONS.

We have read the Athletic Handbook and agree to abide by the standards, rules, and regulations set forth. We agree that if we have any questions or concerns at any time, we will present them to the Athletic Director, Coaches, and Staff of CCA. We agree to support the Athletic Program with our prayers and to also do our part to maintain student/athlete priorities in this order: 1) Relationship with God & spiritual growth, 2) Academic Standards, and 3) Athletics.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete, correct, and agree to the above statements.

Student Signature: _____Date: _____

Parent/Guardian Signature: _____Date: _____

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For School Use Only:

The student's medical history was reviewed, and it was determined that the student _____ does _____does not require a physical examination.

School Representative: _____Date: _____

PHYSICAL EXAMINATION

Student's Name: _____ Gender_____ Age _____ DOB_____
Height _____ Weight_____ Pulse _____ BP_____/_____
Vision: R 20/_____ L 20/___ Corrected: ☐ Yes ☐ No Pupils: ☐ Equal ☐ Unequal

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position.			
Heart-Auscultation of the heart in the standing position.			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only

CLEARANCE

☐ Cleared Comments, if any: _____

☐ Not cleared for (please list the activity) : _____

Medical Professional Name: _____ Date of Exam: _____

Address or Clinic/Hospital: _____

Phone Number: _____ Signature: _____