Liberty Christian School

A Ministry of Palmetto Avenue Baptist Church

SPORTS SCREENING & PHYSICAL FORM

STUDENT'S INFORMATION

School Year 20____ - 20____
Grade _____

____
Last First Middle

______________ ______ ______ ____________________
DOB Age Sex SSN

Home Address

____
Street City State Zip

Parent Contact Information

_____________________ ____________________ ____________________ _____________________
Name Home Phone Cell Phone Work Phone

_____________________ ____________________ ____________________ _____________________
Name Home Phone Cell Phone Work Phone

Emergency Contact Information

_____________________ ____________________ ____________________
Name Home Phone Cell Phone

The student lives with: ___ Biological Parents ___ Mother & Step Father ___Father & Step Mother ___ Other: ____________

MEDICAL INSURANCE INFORMATION

Insurance Policy Number ____

Name of Insurer ____

Address: ____
Street City State Zip

PARENT CONSENT & RELEASE FOR MEDICAL TREATMENT

1. I/We do hereby approve my child participating in approved athletic activities (practice, games, competition, and travel) as a representative of Liberty Christian School.
2. I/We clearly understand that participation in athletic activities creates a rist of severe injury and that the risk increases as the sport becomes more vigorous and involves more bodily contact.
3. I/We acknowledge that Liberty Christian School is not liable for medical expenses (i.e., hospital, physician, emergency transportation, etc.) or other charges incurred for such services, as may be rendered for or on behalf of my child as a result of injury or illness.
4. I/We understand that if my child is injured or becomes ill, Liberty Christian School will not be liable unless the unjiry or illness is the result of negligent conduct on the part of an employee of Liberty Christian School.
5. I/We do hereby approve emergency treatment, as deemed necessary by the hospital and/or medical personnel (physician, physical therapist, emergency medical services, athletic trainer, and coaches) attending to my child.
6. I/We do hereby give permission for the information contained in this Sports Screening and Physical Form to be given to any medical personnel and emergency care facility administering treatment to my child.
7. I/We do understand that this health examination is required before being allowed to participate in high school athletics. I/We further understand that this health examination is entirely voluntary on my part and that part of the doctors; therefore, I agree to release doctors and personnel involved in the examination of any circumstances that might arise (directly or indirectly) from said examination.

SIGNATURES

____________________________ ____________ ___________________________ ____________
Student Athlete Signature Date Parent/Legal Guardian Signature Date

2626 S Palmetto Avenue – Sanford, FL 32773 – 407-323-1583 – www.liberty-patriots.org

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SPORTS SCREENING & PHYSICAL FORM

FAMILY MEDICAL HISTORY: To be completed by parent or legal guardian (Check all that apply)

☐ Blackouts ☐ Blindness ☐ Heart Disease ☐ Kidney Disease ☐ Strokes
☐ Bleeding Disorders ☐ Diabetes ☐ High Blood Pressure ☐ Seizures ☐ Sudden Death

* Please list any confidential medical information on a separate sheet to be retained in the school office.

STUDENT MEDICAL HISTORY: To be completed by parent or legal guardian (Check all that apply)

☐ Anemia
☐ Arthritis
☐ Asthma
☐ Back Pain
☐ Blackouts
☐ Bladder Infection
☐ Blindness
☐ Blood in Urine
☐ Braces
☐ Chest Pain
☐ Collapsed Lung
☐ Concussion
☐ Diabetes
☐ Dislocation
☐ Dizziness
☐ Double Vision
☐ Earaches
☐ Easy Bruising
☐ Fainting
☐ Fractures
☐ Free Bleeding
☐ Glasses/Contacts
☐ Headaches
☐ Heart Murmur
☐ Heart Disease
☐ Heat Stroke
☐ Hernia
☐ High Blood Pressure
☐ Hot/Cold Spells
☐ Jaundice
☐ Retinal Injury
☐ Kidney Problems
☐ Knee Problems
☐ Loss of Paired Organ
☐ Moon
☐ Neck Injury
☐ Nosebleeds
☐ Pneumonia
☐ Poor Hearing
☐ Rapid Heart Beat at Rest
☐ Rheumatic Fever
☐ Seizures
☐ Severe Coughing
☐ Shortness of Breath Spells
☐ Swollen Ankles
☐ TB
☐ Thyroid Disease
☐ Ulcers
☐ Unexplained Fevers
☐ Weak Ankles
☐ Other: ____________________
____

Please provide details regarding any items circled: ____________________

Student has had surgery: ☐ No ☐ Yes If yes, what type? ____________________ Date: __________

Student has been hospitalized: ☐ No ☐ Yes If yes, what reason? ____________________ Date: __________

Student is currently taking medication: ☐ No ☐ Yes If yes, what type? ____________________ Date: __________

Student has allergies: ☐ No ☐ Yes If yes, what type? ____________________ Date: __________

STUDENT INJURY HISTORY: To be completed by parent or legal guardian. Please provide date of injury if applicable.

Ankle (L) (R): ____________________
Arm (L) (R): ____________________
Back: ____________________
Eye (L) (R): ____________________
Hand (L) (R): ____________________
Head: ____________________
Hip (L) (R): ____________________
Knee (L) (R): ____________________
Neck: ____________________
Shoulder Dislocated (L) (R): ____________
Shoulder Separation (L) (R): ____________
Thigh (L) (R): ____________________
Wrist (L) (R): ____________________
Other: ____________________
____

STUDENT PHYSICAL EXAMINATION: To be completed by examining physician.

Height: ____________ Weight: ____________ Resting Pulse: ____________ Blood Pressure: ____________

Visual Acuity:

Right Eye with Glasses: ____________ Left Eye with Glasses: ______________
Right Eye without Glasses: ______________ Left Eye without Glasses: ______________
Sports Participation will Require: ☐ Glasses ☐ Contacts (soft/hard)

Check if Normal: ☐ HEENT ☐ Skin ☐ Chest ☐ Heart ☐ Abdomen ☐ Spine ☐ Neck ☐ Genitalia ☐ Upper/Lower Extremities

Additional Comments: ____________________

PHYSICIAN'S CERTIFICATION:

☐ I certify that I have examined this athlete and find he/she to be able to compete in all supervised athletic activities with the exception of those activities marked below:

☐ Baseball ☐ Cross Country ☐ Gymnastics ☐ Swimming ☐ Weightlifting
☐ Basketball ☐ Football (Tackle) ☐ Lacrosse ☐ Tennis ☐ Wrestling
☐ Bowling ☐ Football (Flag) ☐ Soccer ☐ Track
☐ Cheerleading ☐ Golf ☐ Softball ☐ Volleyball

☐ I do not certify this athlete unless that student has a waiver on file for the following reason: ____________________

____

Physician's Signature

____________________ ______________
Signature Date

Physician's Address

____
Street City State Zip

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