

WEST VIRGINIA CHRISTIAN ATHLETIC ASSOCIATION

PHYSICIANS CERTIFICATE FORM
(Separate form required for each school year)

Student's Name _____ Birthdate ____/____/____

School Year _____ Grade _____ Age _____

Part I – Student's Medical History
(To be completed by parent or guardian prior to examination)

Have you ever had:

- Yes No 1. Chronic or recurrent illnesses? (Diabetes, Asthma, Seizures...)
- Yes No 2. Any hospitalizations?
- Yes No 3. Any surgery (except tonsils)?
- Yes No 4. Any injuries that prohibited your participation in sports?
- Yes No 5. Dizziness, fainting, or frequent headaches?
- Yes No 6. Concussion/knocked out?
- Yes No 7. Knee, ankle, or neck injuries?
- Yes No 8. Broken bone or dislocation?
- Yes No 9. Heat exhaustion/sun stroke?

Do you:

- Yes No 10. Have any allergies?
- Yes No 11. Have any problems with blood pressure/heart?
- Yes No 12. Or has anyone in your family fainted during exercise?
- Yes No 13. Take any medication?
List _____
- Yes No 14. Wear glasses _____ Contact lenses _____
Dental appliances _____
- Yes No 15. Have any organs missing (eye, kidney, testicle, etc.)?
- Yes No 16. Has it been longer than 10 years since your last tetanus shot?
- Yes No 17. Have you ever been told not to participate in any sport?
- Yes No 18. Do you know any reason this student should not participate in sports?
- Yes No 19. Have a sudden death history in your family?
- Yes No 20. Have a family history of heart attack before age 50?

Please explain any "Yes" answers or any other concerns:

I give consent for the above named student to receive a physical examination by a qualified, registered physician as recommended by the named student's school administration.

Signature Parent/Guardian _____ Date ____/____/____

(more information required on back)

Physicians Certificate Form Continued

Part II – Physical Exam

Height _____ Weight _____ Pulse _____ Blood Pressure _____/_____

Visual acuity: Uncorrected _____/_____ Corrected _____/_____
Pupils equal in diameter Y N

Mouth: Appliances: Y N Missing/loose teeth: Y N
Caries needing treatment: Y N

Skin: Any infectious lesion? Y N

Respiratory: Symmetrical breath sounds: Y N Wheezes: Y N

Cardiovascular: Rate _____ Irregularities: Y N
Murmur: Y N Murmur with valsalva: Y N
Peripheral pulses equal: Y N

Genitourinary: Inguinal hernia: Y N
Testicles descended bilaterally: Y N

Musculoskeletal: (Note any abnormalities)

Neck:	Y	N	Knee/Hip:	Y	N
Shoulder:	Y	N	Ankle:	Y	N
Elbow:	Y	N	Hamstrings:	Y	N
Wrist:	Y	N	Scoliosis:	Y	N

Recommendations Based on Above Evaluation:

After my evaluation, I give my

- Full approval
- Full approval; but needs further evaluation by family
- Dentist _____ Eye Doctor _____ Physician _____ Other _____
- Limited approval with following restrictions: _____

- Denial of approval for following reasons: _____

_____ M.D./D.O. Date _____/_____/_____