Tuscaloosa Christian School

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Phone: (205) 553-4303 Fax: (205) 553-4259
www.tcswarriors.org
Established 1969

ATHLETIC DEPARTMENT
SPORTS PHYSICAL

Student's Name: ______________________________ DOB ___/___/____ Age: ___

I wish to compete in interscholastic athletics. I understand it is entirely voluntary on my part. It is with the understanding that I have not violated any of the eligibility rules and regulations of Tuscaloosa Christian School.

Student's Signature: ______________________________ Date: ______________

PARENT OR GUARDIAN PERMISSION

I hereby give my consent for the above-named student to:

- Represent his/her school in athletic activities, except those crossed out on the physical examination form by the physician, provided that such athletic activities are approved by Tuscaloosa Christian School;
- Accompany any school team of which he/she is a member on any of their local or out-of-town trips.

I authorize the school to obtain, through a physician of its own choice, any emergency medical care that may become reasonably necessary for the student in the course of such athletic activities during such travel. I also agree not to hold the school or anyone acting in its behalf responsible for any injury occurring to the above-named student in the course of such athletic activities or such travel.

Parent's Signature: ______________________________ Date: __________

Cell: ______________________ Work phone: ______________________

In case of emergency and parents cannot be reached, another person to contact:

Name: ______________________ Phone: ______________________

INSURANCE COVERAGE

Each student must be covered by insurance before participation in any of the sports mentioned on the physical examination form. The school offers individual insurance coverage that can be purchased. If interested, please check with the school office.

Name of Insurance Company: ______________________ Policy No: ____________

STUDENT / ATHLETE

Medical Release Form

Alabama Christian Athletic Association

Federal guidelines under HIPAA now requires a signed release form to be on file before any medical or financial information can be given on the named patient.

Student / Athlete: ____

Permission to discuss the medical condition of above named patient with the following people is granted for all school related health problems:

1) Athletic Director; 2) Coaches; 3) Trainers; 4) School Administration;
5) Insurance agent (Planned Benefits services)

Signed: ______________________________ **Relationship:** ________________

Signed: ______________________________ **Relationship:** ________________

School: ____

The medical condition of the above named patient is not to be discussed with any person other than the patient and parents or guardians.

Signed: ______________________________ **Relationship:** ________________

Signed: ______________________________ **Relationship:** ________________

Date: _________________________

(Copy One Form Per Athlete)

Revised 2020

Alabama Christian Athletic Association

Medical History / Physical Form

HISTORY

Date________________________

Name____ Sex ______ Age ______ Date of Birth__________________

Address ____ Phone ______________________

School ____Grade________ Sport________________________

Check Yes or No

Explain "Yes" answers below:	**Yes √**	**No √**
1. Has a doctor ever restricted/denied your participation in sports?		
2. Have you ever been hospitalized or spent a night in a hospital?		
Have ever had surgery?		
3. Do you have any ongoing medical conditions (like Diabetes or Asthma)?		
4. Are you presently taking any medications or pills (prescription or over-the-counter)?		
5. Do you have any allergies (medicine, pollens, foods, bees or other stinging insects)?		
6. Have you ever passed out during or after exercise?		
Have you ever been dizzy during or after exercise?		
Have you ever had chest pain or discomfort in your chest during or after exercise?		
Do you tire more quickly than your friends during exercise?		
Have you ever had high blood pressure?		
Have you ever been told that you have a heart murmur, high cholesterol, or heart infection?		
Have you ever had racing of your heart or skipped heartbeats?		
Has anyone in your family died of heart problems or a sudden death before age 50?		
Does anyone in your family have a heart condition?		
Has a doctor ever ordered a test on your heart (EKG, echocardiogram)?		
7. Do you have any skin problems (itching, rashes, staph, MRSA, acne)?		
8. Have you ever had a head injury or concussion?		
Have you ever been knocked out or unconscious?		
Have you ever had a seizure?		
Have you ever had a stinger, burner, pinched nerve, or loss of feeling or weakness in your arms or legs?		
9. Have you ever had heat or muscle cramps?		
Have you ever been dizzy or passed out in the heat?		
10. Do you have trouble breathing or do you cough during or after activity?		
Do you take any medication for asthma (for instance, inhalers)?		
11. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?		
12. Have you had any problems with your eyes or vision?		
Do you wear glasses or contacts or protective eye wear?		
13. Have you had any other medical problems (infectious mononucleosis, diabetes, infectious diseases, etc.)?		
14. Have you had a medical problem or injury since your last evaluation?		
15. Have you ever been told you have sickle cell trait?		
Has anyone in your family had sickle cell disease or sickle cell trait?		
16. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? ( ) Head ( ) Back ( ) Shoulder ( ) Forearm ( ) Hand ( ) Hip ( ) Knee ( ) Ankle ( ) Neck ( ) Chest ( ) Elbow ( ) Wrist ( ) Finger ( ) Thigh ( ) Shin ( ) Foot		
17. When was your first menstrual period? ________________________________ **When was your last menstrual period?** ________________________________ **What was the longest time between your periods last year?**		
Explain "Yes" answers:		

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

Duplicate as Needed

Signature of athlete ______________________________ Date ______________

Signature of parent/guardian ______________________________

In order for any student to be eligible for interscholastic athletics, there must be on file in your school's office a current Medical History Form (signed by a physician) certifying that the student has passed a physical exam, and that in the opinion of the examining physician (M.D. or D.O.) the student is fully able to participate in interscholastic athletics. **A physical exam will satisfy the requirement for one calendar year from the date of the exam.**

PHYSICAL EXAMINATION

Height ____________ Weight ____________ BP ________ / ________ Pulse ____________

Vision R 20/________ L 20/________ Corrected: Yes or No

	Normal	Abnormal Findings
Cardiovascular		
Pulses		
Heart		
Lungs		
Skin		
E.N.T.		
Abdominal		
Genitalia (males)		
Musculoskeletal		
Neck		
Shoulder		
Elbow		
Wrist		
Hand		
Back		
Knee		
Ankle		
Foot		
Other		

Clearance:

A. Cleared

B. Cleared after completing evaluation/rehabilitation for: ______________________________

C. Not cleared for: ( ) Collision ( ) Contact

( ) Non-contact _____ Strenuous _____ Moderately strenuous _____ Non-strenuous

Due to: ______________________________

Recommendation: ______________________________

____

____

Name of physician ______________________________ Date ______________

Address ______________________________ Phone ______________

Signature of physician ______________________________, M.D. or D.O.

(This form must be signed and dated by the attending physician.)