DATE: _____ SPORT: _____

Faith Christian Academy
Student/Athlete Physical Examination Record

_____ _____
LAST NAME FIRST MIDDLE DATE OF BIRTH

_____ _____
CELL PHONE NUMBER LOCAL PHONE #

_____
STREET NUMBER & NAME CITY STATE ZIP

_____ _____
PARENT/GUARDIAN NAME PARENT/GUARDIAN PHONE NUMBER

_____
STREET NUMBER & NAME CITY STATE ZIP

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1. Have you been advised by a physician in the past five (5) years to restrict activity? YES ☐ NO ☐

2. Are you under a physician's care now? YES ☐ NO ☐

3. Have you been seen by a physician within the past year? YES ☐ NO ☐

4. Are you on any medication at the present time? YES ☐ NO ☐
If yes, please list name(s): _____

5. Do you wear Glasses ☐ Contact lenses ☐ Bridgework ☐ Dental braces ☐? YES ☐ NO ☐
Date of last visit to dentist: _____

6. Have you ever had a surgical operation? YES ☐ NO ☐

7. Have you ever been confined to a hospital? YES ☐ NO ☐

8. Have you had any illness or infection lasting more than one (1) week? YES ☐ NO ☐

9. Have you had any injuries requiring medical attention? YES ☐ NO ☐

10. Were you temporarily disabled? YES ☐ NO ☐
If yes, how long: _____

11. Have you ever had Back Pain ☐ Shoulder dislocation ☐, Ankle sprain ☐
Knee trouble ☐ or Knee cap dislocation ☐? YES ☐ NO ☐

12. Have you ever been knocked unconscious? YES ☐ NO ☐
If yes, how many times? _____
Were you evaluated by a physician? YES ☐ NO ☐
Were you hospitalized? YES ☐ NO ☐

13. Have you ever fainted?
If yes, how many times? _____

14. Do you have frequent headaches? YES ☐ NO ☐

15. Have you had convulsions? YES ☐ NO ☐
If yes, how many times? _____

16. Have you ever become weak or ill when exposed to high temperature? YES ☐ NO ☐

17. Any loss or seriously impaired function of any paired organ for example;
(Eyes ☐ Lungs ☐ Kidneys ☐ or Testicles ☐?) YES ☐ NO ☐

18. Do you have or have you ever had Asthma/Hay Fever Allergies? YES ☐ NO ☐
If yes, to what? _____

19. Do you have or have you had any of the following:

Diabetes	YES ☐	NO ☐
Heart Disease (rheumatic fever, high blood pressure, murmurs?)	YES ☐	NO ☐
Epilepsy?	YES ☐	NO ☐
Abnormal bleeding tendencies?	YES ☐	NO ☐
Kidney disease?	YES ☐	NO ☐
Tuberculosis?	YES ☐	NO ☐
Stomach/Intestinal trouble?	YES ☐	NO ☐
Arthritis?	YES ☐	NO ☐

Please elaborate below on any of the above questions with a "yes" answer & explain any surgeries including the year:

Parent's Signature: _____

Height	Neck	
Weight	Abdomen	
Pulse	Back	
P.P.	Genitalia	
Eye/Ear	Knees	
Nose/Throat	Extremities	
Heart	Immunization	
Lungs		

Comments: _____

Doctor's Signature: _____ Date: _____

Return to: Faith Christian Academy
450 West Elm Ave.
Coalinga, CA 93210