MEDICAL HISTORY QUESTIONNAIRE

PARENTS - PLEASE COMPLETE & SIGN.

NAME OF STUDENT____

AGE____________ GRADE________________ SEX M/F

NAME OF PARENT OR GUARDIAN____________________________________

MAILING ADDRESS ____

NAME OF STUDENT'S PHYSICIAN____________________________________

Has your son/daughter ever had any of the following:

All of the following questions must be answered YES OR NO:

	Yes	No
High blood pressure		
Heart disease		
Frequent chest pains or palpitations		
History of a family member having sudden death		
Asthma		
Diabetes		
History of fatigue and undue tiredness		
Epilepsy, seizures or convulsions		
Concussion or other head injury requiring hospitalization		
Experienced loss of consciousness after injury		
History of fainting with exercise		
Operations (Not stitches for lacerations)		
Fractures (broken bones) or dislocation		
Any serious illnesses not mentioned above		
Allergies		
Does he/she take any medication on a regular basis other than for allergies?		
MEDICATION and dosage:		
Is he/she currently under the care of a physician for a medical or a surgical problem?		
Has he/she been medically advised not to participate in any sport?		

If the answer to any of the above is YES, indicate date and give details below.

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SIGNATURE OF PARENT OR GUARDIAN________________________ DATE __________

TELEPHONE NUMBER ____

(OVER)

TO BE COMPLETED BY A PRACTICING PHYSICIAN

LIFE CENTER ACADEMY
2045 Burllngton-Columbus Road
Burlington, NJ 08016
609-499-2100

SPORTS MEDICAL EXAMINATION

____

Last Name First Name (Birth) Month Day Year

I have examined the general physical condition of the above named student and find said student to be physically fit to participate in athletic activities. Findings of the physical examination are noted below.

HEIGHT____________ WEIGHT____________ BLOOD PRESSURE____________

RESTING PULSE__________________ PULSE AFTER EXERCISE__________________

Neuromuscular	Pass	Fail
Vision — glasses	Yes	No
Hearing	Pass	Fail
Skin — Condition	Pass	Fail
Ears/Nose/Throat	Pass	Fail
Lungs	Pass	Fail
Heart	Pass	Fail
Abdomen	Pass	Fail
Hernia	Pass	Fail
Physical Maturation	Pass	Fail

(Attach additional comments):

ON THE BASIS OF THE MEDICAL HISTORY AND THIS EXAMINATION, I APPROVE THIS CHILD'S PARTICIPATION IN: (for one year)
(If no, please attach explanation)

SPORTS	Yes	No
PE	Yes	No

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PHYSICIAN'S SIGNATURE DATE

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PHYSICIAN'S ADDRESS TELEPHONE #