

**Medical History Form (Completed by parents & students)**

This **Medical History Form** must be submitted to Coach for delivery to Athletic Department in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition, which would make it hazardous to participate in an athletic event.

During the past 12 months	Yes	No
1. Was s/he hospitalized?	_____	_____
2. Did s/he have any injuries requiring medical attention?	_____	_____
3. Did s/he have any illness lasting more than one week?	_____	_____
4. Does s/he take medication regularly?	_____	_____
5. Do you know of any reason why there should be limits in his/her participating? in any sport?	_____	_____
6. Has s/he ever had a concussion or been knocked unconscious?	_____	_____
7. Has s/he ever had a convulsion?	_____	_____
8. Is s/he now under a doctor's care?	_____	_____
9. Is s/he missing any paired organ (eye, kidney, etc.)?	_____	_____
10. Is s/he wearing any removable dental appliance (bridge, plate, retainer)?	_____	_____
11. Is s/he allergic to any medication (aspirin, Tylenol, etc)?	_____	_____
12. What year was the last tetanus booster given?		_____

It is understood that even though the athlete whenever needed wears protective equipment, the possibility of an accident still remains. Neither Texas Association of Private and Parochial Schools, nor Bay Area Christian School assumes the responsibility in case an accident occurs. If, in the judgment of any representative of BACS, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize and consent to such care and treatment as may be given said student by any physician, trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person because of such care and treatment of said student. If, between this date and the beginning of athletic competition, any illness or injury should occur that might limit this student's participation, I agree to notify the school authorities of such illness or injury.

Student Signature _____	Date _____
Parent/Guardian Signature _____	Date _____

**BACS MEDICAL HISTORY AND PHYSICAL EXAMINATION FORM**  
**\*\*Must be completed before a student participates in any practice**

Students Name \_\_\_\_\_ Circle One      Male      Female

Parent/Guardian \_\_\_\_\_ Student Date of Birth \_\_\_\_\_

Family Doctor or Clinic's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Family Dentist or Clinic's Name \_\_\_\_\_ Phone # \_\_\_\_\_

As a minimum requirement, this Physical Examination Form <b>must be completed</b> prior to high school/junior high athletic competition. It must be completed if there are yes answers to specific question on the student's Medical History Form above.
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**COMPLETE BLANK SPACES**  
**To be completed by examining physician**

Weight \_\_\_\_\_      Height \_\_\_\_\_      Pulse \_\_\_\_\_      Blood Pressure \_\_\_\_\_

Legend:      N = Normal      X = Abnormal      NE = Not examined

General Body Build \_\_\_\_      Skin \_\_\_\_      Eyes \_\_\_\_      Nose \_\_\_\_      Throat \_\_\_\_      Teeth \_\_\_\_      Neck \_\_\_\_      Lungs \_\_\_\_

Heart \_\_\_\_      Chest \_\_\_\_      Liver \_\_\_\_      Spleen \_\_\_\_      Spine \_\_\_\_      Abdominal Masses \_\_\_\_

Joint Function:      Neck \_\_\_\_      Shoulder \_\_\_\_      Elbows \_\_\_\_      Wrists \_\_\_\_      Hands \_\_\_\_      Hips \_\_\_\_      Knees \_\_\_\_

Ankles \_\_\_\_      Feet \_\_\_\_      Neurological \_\_\_\_      Hernia \_\_\_\_      Genitalia (Male only) \_\_\_\_

Description of abnormal findings: \_\_\_\_\_

I certify that I have examined this student and s/he may compete in supervised school activities with the exception of the following specific activities (please circle any activity from which this student should be excluded):

Baseball      Basketball      Cross Country      Golf      Soccer      Softball

Volleyball      Cheerleading      Track & Field

Special Instructions or Special Limitations: \_\_\_\_\_

Printed Name of Physician: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Exam Date: \_\_\_\_\_