LIGHTHOUSE BAPTIST ACADEMY
Parental Consent/Physical Examination Form
Separate examination is required for each school year

PART I – Student Information

Students Name: _____
(Last) (First) (Middle Initial)

Home Address: _____

City/Zip Code: _____

Date of Birth: _____

Name of Parents: _____

PART II – Medical History
This form must be completed by parent or guardian prior to the physical examination and should be taken with the physical examination form for review by the physician during the examination.

Please explain any YES answers.

1. Have you ever had any of the following?

_____ heart murmur _____

_____ high blood pressure _____

_____ other heart problems _____

_____ broken bones _____

_____ weak joints-ankles, knees _____

_____ concussion _____

_____ operation _____

_____ seizures or epilepsy _____

2. Have you ever fainted or passed out? _____

3. Have you ever been knocked out? _____

4. Have you ever been hospitalized?_____

5. Have you ever had to stop running after ¼ to ½ miles for chest pain or shortness of breath?
_____

6. Have you ever had significant allergies to:

_____ bee stings? - On medication – yes__ no__

_____ foods _____

_____ medicine _____

_____ others _____

7. Do you have prescription for use of:

_____ Adrenaline _____

_____ Inhalers _____

_____ Other allergy medicine _____

8. Do you have asthma?

_____

9. Do you take any medicine regularly (list type and dosage)?_____

_____

10. Have you had any illnesses lasting a week or more such as mononucleosis, etc.? _____

_____

11. Have you had any blood disorders, including sickle cell trait, anemia, etc.? _____

_____

12. Has any family member had a heart attack, heart problems or sudden death before the age of 50? ____

_____

13. Do you wear contact lenses, eyeglasses or dental appliance? _____

_____

14. Do you have any missing or non-functioning organs such as testes, eye, kidney, etc.? _____

_____

15. Have you begun menses yet? _____

_____

16. Do you have any other significant health problems? _____

_____

17. Hepatitis B Immunization Series? _____

_____

DATE OF LAST TETNUS IMMUNIZATION? _____

Parent/Guardian Signature:_____

PART III – Physical Examination
(To be completed and signed by examining physician)

NAME: _____
HEIGHT _____
WEIGHT _____ SEX _____ AGE
*Tanner Stage or Maturation Index
BP
*Percent Body Fat
*Pulse (rest)
(Exercise)
(Recovery)
*Vision: Corrected (L) (R) Both _____
Uncorrected (L) (R) Both_____
*Audiogram:
Cervical spine/neck
Back
Eyes
Shoulders
Ears
Arm/elbow/wrist/hand
Nose
Knees/hips
Throat
Ankles/feet
Teeth
Skin
Lab:
Lymphatic
*Urine
Lungs
*Hemoglobin or HCT
Heart
and/or Fe Stores
Abdomen
Genitalia/hernia
Peripheral pulses
*WHEN MEDICALLY INDICATED
I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics.
_____ Full Participation
_____ Limited Participation
_____ No Participation
_____ Needs Additional Evaluation
If not full participation give reasons & recommendations:
Any recommendations or concerns on such items as:
a. Weight loss or gain or restrictions of weight loss: _____
b. Slow and careful monitoring of conditioning because of being overweight or show an abnormal exercise testing:
_____
Physician Signature
M.D.* Date
*Doctor of Medicine, Doctor of Osteopathy or Licensed Nurse Practitioner
Physician Name (print)
Address
City/Zip Code
Telephone Number

PART IV – Acknowledgement of risk and insurance statement
(To be completed and signed by parent/guardian)

I give permission for _____(name of child/ward) to participate in any of the following sports that are not crossed out: baseball, basketball, cheerleading, soccer, softball, volleyball, other (identify sports).

_____

I have reviewed and understand the individual eligibility rules and I am aware that with the participation in sports comes the risk of injury to my child/ward. I understand that the degree of danger and the seriousness of the risk varies significantly from one sport to another with contact sports carrying the higher risk. I have had an opportunity to understand the risk inherent in sports through meetings, written handouts, or some other means. Student/child is insured by our family policy with:
Name of Company: _____
Policy Number: _____
Name of Policy Holder: _____

I am aware that participating in sports will involve travel with the team. I acknowledge and accept the risks inherent in the sport and with the travel involved and with this knowledge in mind, grant permission for my child/ward to participate in the sport and travel with the team. By this signature, I hereby consent to allow the physician(s) and other heath care provider(s) selected by myself or the school to perform a pre-participation examination on my child and to provide treatment for any injury or condition resulting from participating in athletics/activities for his/her school during the school year covered by this form. I further consent to allow said physician(s) or health care provider(s) to share appropriate information concerning my child that is relevant to participation in athletics and activities with coaches and other school personnel as deemed necessary. Additionally I give my consent and approval for the above named student's picture and name to be printed in any MCA school or athletic program publication or video.

PART V – Emergency Permission Form
(To be completed and signed by parent/guardian)

STUDENT'S NAME: _____
GRADE: _____
AGE: _____
SCHOOL: _____

Please list any significant health problems that might be significant to a physician evaluating your child in case of an emergency

_____
_____

Please list any allergies to medications, etc.

_____
_____
Has student been prescribed an inhaler or epipen?_____
Is student presently taking medication? _____If so, what type _____
_____
Does student wear contact lenses?_____ Please list date of last tetanus shot_____

EMERGENCY AUTHORIZATION:

In the event I cannot be reached in an emergency, I hereby give permission to physicians selected by the coaches and staff of Lighthouse Baptist Academy to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for the person named above.
Daytime phone number (where to reach you in emergency):

_____

Evening time phone number (cell phone or number where to reach you in emergency):

_____

Name, relationship and phone number of alternative person to be contacted in the event of an emergency: _____

Signature of parent or guardian (must be notarized/signed in the presence of a Notary):

_____ Date: _____

Notary Information and Seal Below

Emergency Permission Form may be reproduced to travel with respective teams and is acceptable for emergency treatment if needed.