Lancaster Baptist School

Preparticipation Physical Exam Form
Athletic Department

Name_____ Grade_____ Date_____
Address_____ Age_____
City_____ Zip_____ Date of Birth_____
Phone_____ Mobile_____ Gender_____
Sports_____
Emergency Contact_____ Phone_____

1. Are you currently under a physician's care for any reason?	Yes	No
2. Are you currently taking any prescription medication?	Yes	No
3. Are you allergic to any medication to the best of your knowledge?	Yes	No
4. Have you ever been told that you have asthma?	Yes	No
5. Do you have any allergies?	Yes	No
6. Have you been knocked unconscious at any time during the past year?	Yes	No
7. Do you need a tetanus booster (usually once every ten years)?	Yes	No
8. Do you have only one working organ of a usually paired organ? (Ex: only one ear, eye, kidney, lung, etc.)	Yes	No
9. Do you know of, or believe there is any health reason why you Should not participate in interscholastic athletics?	Yes	No

If you answered yes to any of the above questions, indicate the question number and give a brief explanation.
No. _____ Explain: _____
No. _____ Explain: _____
No. _____ Explain: _____

Signature of Parent/Guardian_____ **Date**_____

TO BE COMPLETED BY THE PHYSICIAN

Physician: please indicate in the space provided by each topic if there is a deficiency that should be noted.
Height_____ Weight _____ Blood Pressure_____
Vision: Usually wears: Glasses Contacts Neither
Test done with: Glasses Contacts Neither
Right_____ Left_____
Heart _____ Skin_____ Teeth_____
Lungs_____ Orthopedic_____

Additional remarks: _____
_____
Sports Participation approved: Yes _____ No _____ Restricted _____

Limitations _____

Signature of Physician_____ **Date**_____

MEDICAL INFORMATION AND RELEASE
LANCASTER BAPTIST SCHOOL- 2015

California Interscholastic Federation

My child, _____ has my permission to travel to and from CIF Athletic events with the team for which he/she is participating. I/we, _____, do authorize the hospital chosen by the coaches or (state hospital preference) to any X-Ray examination, anesthetic, medical, or surgical diagnosis or treatment, and hospital care which may be deemed advisable by and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of said hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. The parents would be contacted should such emergency arise. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, and is given to provide authority and power on the part of our aforesaid agents to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. This authorization shall remain in effect for the duration of the school year during games, practices, and while traveling to either, for any and all sports participated in by student during this school year.

Address: _____

Father Work Phone: _____ Father Cell Phone: _____

Mother Work Phone: _____ Mother Cell Phone: _____

Home Phone: _____ Other Phone: _____

Doctor Name: _____ Doctor Phone: _____

Insurance Carrier: _____ Policy Number: _____

Sport: _____**FOOTBALL**_____

**I understand there is an athletic fee of $420 that is required for my student to play football*

***$210 will be due September 1st and the remaining $210 will be due on November 1st*

Parent Signature: _____ Print Name: _____