ATHLETIC PHYSICAL & PARENT CONSENT 2023-2024

Calvary Christian Academy
1771 E. Palomar Street, Chula Vista, CA 91913
Phone: (619) 591-2260 Fax: (619) 591-2261

Student's Name _____ / /
(Last) (First) (Sex / Birthdate / Grade)

Circle the sports(s) that you will be playing:

Elementary: **Fall: Boys Flag-Football / Girls Volley-Tennis** **Winter: Boys/Girls Basketball** **Spring: Coed Soccer**

Middle School: **Fall: Boys Flag-Football / Girls Volleyball** **Winter: Boys/Girls Basketball** **Spring: Coed Soccer**

Address **City/State** **Zip**

Mother Address: (if different) Home #	Father Address: (if different) Home #
Work # Cell #	Work # Cell #

Emergency Contact: Home # Work #

Ins. Co. Family Dr.
Tel. #

Policy # Height: Weight: BP:
Vision: R L

Parents: Please Complete			Physician: Please Complete		
HEALTH HISTORY	**NO**	**YES-COMMENT**	**VITALS**	**-**	**+ - COMMENT**
Chronic Illness			Abdomen		
Current medications			Elbows		
Dental appliances			Feet/Toes/Ankles		
Hearing defects			Head		
Have you ever had heat cramps?			Heart		
Passed out during exercise (heat)?			Hips / Pelvis		
Dizzy during exercise (heat)?			Knees		
Ever had chest pain?			Lungs		
Do you tire easily when exercising?			Shoulders		
Ever had high blood pressure?			Spine		
Have you ever had a heart murmur?			Wrist/Hnds/Fngrs		
Racing heart or skip a beat?					
History of family heart problems?					
Family history of Marfan's Syndrome?					
Do you have any skin problems?					
Have you ever had a head injury?					
Have you ever been knocked out?					
Have you ever had a seizure?					
Have you ever had a stinger?					
Do you use special pads or braces?					

Sports Participation: Yes ____ No ____
Limitations:

Further evaluation required: Yes___ No___

x _____
Physician signature Date

Have you ever had:

___Mononucleosis ___Diabetes ___Measles ___Hernia(s)
___Hepatitis ___Headaches ___Asthma ___Ulcers
___Eye Injunes ___Ear Injunes ___Tuberculosis

For females:

When was your first period and how old were you? _____
When was your last period? _____
Are your periods: ___Regular/Monthly ___Irregular/skip months

Please feel free to ask the doctor to address any questions/concerns that you may have. All discussions are kept confidential.

TO REPLY BY FAX: (619) 591-2261

PARENT CONSENT

I give my consent for _____ to compete in sports and travel with a school representative. If injured, this is my authorization for medical treatment. I understand that CCA disclaims any financial responsibility for the cost(s) of medical treatment, hospitals, etc. arising out of injury to my child while participating in interscholastic competition.

x _____
Parent / Guardian signature Date

Student's Name
(Last) (First) (Sex)