West Virginia Christian Education Association Athletics
Physicians Certification Form
(A new form is required each school year.)

Student's Name _____Birthdate _____

School Year _____ Grade _____ Age _____

Part I - Student's Medical History
(This part is to be completed by parent/guardian prior to examination.)

Have you ever had:

Yes	No	1. Chronic or recurrent illnesses? (Diabetes, asthma, seizures…)
Yes	No	2. Any hospitalizations?
Yes	No	3. Any surgery (except tonsillectomy)?
Yes	No	4. Any injuries that prohibited your participation in sports?
Yes	No	5. Dizziness, fainting, or frequent head injuries?
Yes	No	6. Concussion/knocked out?
Yes	No	7. Knee, ankle, or neck injuries?
Yes	No	8. Broken bone or dislocation?
Yes	No	9. Heat exhaustion or stroke?

Do you:

Yes	No	10. Have any allergies? _____
Yes	No	11. Have any problems with blood pressure/heart?
Yes	No	12. Have a family member that has fainted during exercise?
Yes	No	13. Take any medication?
		List: _____
Yes	No	14. Wear glasses _____ contact lenses ___ Dental appliances _____
Yes	No	15. Have organs missing?
Yes	No	16. Has it been longer than 10 years since your last tetanus shot?
Yes	No	17. Have you ever been told not to participate in a sport?
Yes	No	18. Do you know of any reason this student should not participate in a sport?
Yes	No	19. Have a sudden death history in your family?
Yes	No	20. Have a family history of heart attack before age 50?

Please explain any "Yes" answers or any other concerns:

I give consent for the above named student to receive a physical examination by a qualified, registered physician as recommended by the named student's school administration.

Signature of Parent/Guardian: _____ Date _____

PHYSICIANS CERTIFICATE FORM CONTINUED…
(This side is to be filled out by a certified physician.)

Part II - Physical Exam

Height _____ Weight _____. Pulse _____ Blood Pressure _____

Visual Acuity: Uncorrected _____/_____. Corrected _____ /_____
Pupils equal in diameter: Yes No

Mouth: Appliances: Yes No Missing/loose teeth: Yes No
Caries needing treatment: Yes No

Respiratory: Symmetrical breath sounds: Yes No Wheezes: Yes No

Cardiovascular: Rate _____ Irregularities: Yes No
Murmur: Yes No Murmur with valsalva: Yes No
Peripheral pulses equal: Yes No

Genitourinary: Inguinal hernia: Yes No
Testicles descended bilaterally. Yes No

Musculoskeletal: (Note any abnormalities)

Neck:	Yes	No	Knee/Hip:	Yes	No
Shoulder:	Yes	No	Ankle:	Yes	No
Elbow:	Yes	No	Hamstrings:	Yes	No
Wrist:	Yes	No	Scoliosis:	Yes	No

Recommendations based on above evaluation:

After my evaluation, I give my

- ○ Full approval
- ○ Full approval, but needs evaluation by
  - ○ Dentist.
  - ○ Eye Doctor
  - ○ Physician
  - ○ Other
- ○ Limited approval with following restrictions:_____
_____
- ○ Denial of approval for following reasons: _____
_____
_____

_____ MD/DO Date _____