Berean Christian High School
245 El Divisadero Ave.
Walnut Creek, Ca 94598
Phone: (925) 945-6464 Fax: (925) 945-7473

Sports Health Questionnaire (page 1 of 2)

Name:	**Date of Birth:**
Address:	**Grade:**
Parent/Guardian:	**Home Phone:**

Emergency Information

Physician _____ Phone _____
If Physician is unavailable, do we have permission to take your child to a hospital? Yes _____ No _____
Preference of Hospital _____

History

- Allergies: _____
- Any medications, medicine, drugs being taken? _____
  _____
- Heart murmur? Heart disease? Any family history of heart attack under 50 years of age?
  _____
- Do you have to stop when running a half a mile? Yes _____ No _____
- Have you ever been unconscious or knocked out (concussion)? Yes _____ No _____
  _____
- Do you wear glasses/contacts? Yes _____ No _____
  Have you ever had a problem with your eyes? Yes _____ No _____
  Your ears? _____ with hernia? _____ testicles? _____ kidney (urine)? _____
- Female menstrual history: age of onset _____ frequency _____ duration _____
  Problems? _____
  _____
- Major medical illnesses (seizures, anemia, diabetes, arthritis, bleeding disorder, hepatitis, mono, etc.)_____
  _____
- Overnight hospitalizations: _____
- Operations or surgery: _____
- Strains, Sprains or Fractures: _____
- Ever had an x-ray of a bone or joint or had a cast, splint, cane or crutches?
  _____
  _____
- Ever had an injury that caused you to miss a practice or game?
  _____
  _____
- Are you being treated by a physician how?
  _____
  _____

Berean Christian High School
245 El Divisadero Ave.
Walnut Creek, Ca 94598
Phone: (925) 945-6464 Fax: (925) 945-7473

Physical Examination (page 2 of 2)

Date: Age:

Name: Grade:

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Skin:

Respiratory:

Cardio-vascular:

Abdomen: Liver

Spleen

Hernia

Neurological:

Musculo-skeletal:

Specific muscle weakness or atrophy:

Joint instability or limitation of motion:

Assessment (Please check one)

- Cleared for all physical activity
- Cleared after completing evaluation/rehabilitation for: _____
- Not cleared for: _____ Reason: _____

Signed: _____ Date: _____

Physician's Address: Phone Number:

_____ _____

_____

_____