WEST VIRGINIA CHRISTIAN ATHLETIC ASSOCIATION

PHYSICIANS CERTIFICATE FORM
(Separate form required for each school year)

Student's Name _____ Birthdate ____/____/____

School Year _____ Grade _____ Age _____

Part I – Student's Medical History
(To be completed by parent or 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 tonsils)?
Yes	No	4.	Any injuries that prohibited your participation in sports?
Yes	No	5.	Dizziness, fainting, or frequent headaches?
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/sun stroke?

Do you:

Yes	No	10.	Have any allergies?
Yes	No	11.	Have any problems with blood pressure/heart?
Yes	No	12.	Or has anyone in your family fainted during exercise?
Yes	No	13.	Take any medication? List _____
Yes	No	14.	Wear glasses _____ Contact lenses _____ Dental appliances _____
Yes	No	15.	Have any organs missing (eye, kidney, testicle, etc.)?
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 any sport?
Yes	No	18.	Do you know any reason this student should not participate in sports?
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 Parent/Guardian _____ Date ____/____/___

(more information required on back)

Part II – Physical Exam

Height _____ Weight _____ Pulse _____ Blood Pressure _____/_____

Visual acuity: Uncorrected _____/_____ Corrected _____/_____
Pupils equal in diameter Y N

Mouth: Appliances: Y N Missing/loose teeth: Y N
Caries needing treatment: Y N

Skin: Any infectious lesion? Y N

Respiratory: Symmetrical breath sounds: Y N Wheezes: Y N

Cardiovascular: Rate _____ Irregularities: Y N
Murmur: Y N Murmur with valsalva: Y N
Peripheral pulses equal: Y N

Genitourinary: Inguinal hernia: Y N
Testicles descended bilaterally: Y N

Musculoskeletal: (Note any abnormalities)

Neck:	Y	N	Knee/Hip:	Y	N
Shoulder:	Y	N	Ankle:	Y	N
Elbow:	Y	N	Hamstrings:	Y	N
Wrist:	Y	N	Scoliosis:	Y	N

Recommendations Based on Above Evaluation:

After my evaluation, I give my

- ❑ Full approval
- ❑ Full approval; but needs further evaluation by family
- ❑ Dentist _____ Eye Doctor _____ Physician _____ Other _____
- ❑ Limited approval with following restrictions: _____
  _____
- ❑ Denial of approval for following reasons: _____
  _____
  _____

_____ M.D./D.O. Date _____/_____/_____

West Virginia Christian Athletic Association
MEDICAL TREATMENT / LIABILITY RELEASE

I, the undersigned parent or guardian, do hereby grant for my child, whose name is _____ and hereinafter shall be referred to as “participant”, to participate in the West Virginia Christian Athletic Association _____ (sport) Tournament. I grant my permission for said participant to receive the necessary medical treatment in the event of an injury or illness. I hereby hold the West Virginia Christian Athletic Association (including its representatives) and the hosting institution and their personnel harmless in the exercise of this authority.

I further acknowledge, understand and agree that in taking part in this competition, there is possibility and even inherent risk of physical injury or illness and that participant is assuming the risk of such illness or injury by participation.

I further agree to hold harmless the West Virginia Christian Athletic Association and the hosting institution from any and all liability for any claim whatsoever, including any claim arising out of any injury or illness incurred by participation during the course of the tournament including, but not limited to practices, competitions, and/or other activity associated with the course of the tournament, including travel to and from such activity.

WAIVER OF LIABILITY

I hereby waive and absolve the West Virginia Christian Athletic Association (including its representatives) and the hosting institution and its personnel of any liability and responsibility of injuries, sickness, accidents and/or acts of God incurred during participation in the state tournament competition and/or any other related activity by my child (enter participant’s name) _____. In consideration my signed release allowing my child to participate in the West Virginia Christian Athletic Association Tournament, I, intending to be legally bound, do hereby, my heirs, executor and administration, waive, release and forever discharge any and all rights and claims for damage which my child (previously named) known as participant or I may have or which may hereafter accrue to me or my participant child against the West Virginia Christian Association and (including its representatives) and the hosting institution and its personnel for any participation in or rising out of travel to and/or return from the WVCAA tournament. In the event of injury/accident/sickness, West Virginia Christian Athletic Association or the hosting institution are to contact the designated adult listed below as soon as possible to the best of their ability.

_____ _____
Signature of Child/Participant Date of Birth of Participant

_____
Signature of Parent/Guardian

_____
Mailing Address of Participant including City/State/Zip

_____
Emergency Phone Number Date signed

(more information required on back)

WVCAA Medical Treatment / Liability Release Continued

_____
School Participant is Representing

THIS FORM MUST BE IN THE PRESENCE OF THE HEAD COACH OF EACH TEAM DURING THE WVCAA TOURNAMENT. If used to obtain medical treatment, it will be returned to the head coach.

I HEREBY GRANT PERMISSION FOR THE NAMED PARTICPANT, MY CHILD/CHARGE, TO BE TREATED IN CASE OF EMERENCY ACCIDENT OR ILLNESS.

Name of Participant _____

Name of Emergency Contact _____
Relationship _____

Daytime Phone (_____) _____
Evening Phone (_____) _____

THIS FORM DOES NOT CONSTITUTE ANY PAYMENT OBLIGATION ON THE PART OF THE WEST VIRGINIA CHRISTIAN ATHLETIC ASSOCIATION OR THE HOSTING INSTITUTION.

Insurance Information

Name of Company _____
Policy/Group # _____

Doctor's Name _____
Doctor's Phone (_____) _____

Allergies _____

ELK VALLEY CHRISTIAN SCHOOL

Parent Permission/Insurance and Medial Information
For Student Athletes and Cheerleaders

Student Name: _____ Sex: _____

Address: _____

_____ Phone: _____

Parent/Guardian Names: _____

Parent/Guardian Occupation/Employer: _____

Work or Cell Phone: _____ Family Doctor: _____

Corrective Lenses/Type: _____

Physical Handicaps: _____

Surgeries: _____

Previous Physical Injuries (affecting present performance): _____

_____

Indicate problems with any of the following conditions (circle condition/explain on reverse):

Allergies	Asthma	Bee Stings	Diabetes
Epilepsy	Fainting	Heart condition	Hemophilia
Hepatitis	Hypertension	Migraines	Mononucleosis
Nausea	Nerves		

Is the student currently taking non-prescription or prescription medication (name and dosage)?

_____

_____

List any known medication(s) student is allergic to: _____

_____

In case of emergency, contact: _____
At: _____

Insurance Company Name: _____
Group/Policy # _____
Person Responsible for Medical Bills: _____

I / We, _____, give permission for my child, _____, to participate in the Sports Activities Program at Elk Valley Christian School. In the event of injury or illness, I give permission for medical treatment deemed necessary by the Coach, other school officials, or medical personnel to be rendered.

_____ _____
Signature of Parent / Guardian Date