Potential Christian Academy Athlete Medical History Form

School Name: _____
Sport/Activity: _____
Grade: _____
Date: ____ / ____ / _____

Student Information

- **Full Name:** _____
- **Date of Birth:** ____ / ____ / _____
- **Gender:** ☐ Male ☐ Female ☐ Other ☐ Prefer not to say
- **Parent/Guardian Name(s):** _____
- **Primary Phone Number:** _____
- **Alternate Phone Number:** _____
- **Emergency Contact (if different):** _____
- **Relationship:** _____ Phone: _____

Medical History

Please check all that apply and provide explanations where necessary.

1. Injuries
☐ No history of injuries
☐ Sprains (ankle, wrist, etc.)
☐ Broken bones
☐ Concussions
☐ Other (please specify): _____

Details (include dates, treatment, and if recovered):

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2. Surgeries

☐ No surgeries

☐ Yes (please specify): _____

Type of surgery, date, and recovery status:

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3. Allergies

☐ No known allergies

☐ Food allergies (please list): _____

☐ Medication allergies (please list): _____

☐ Environmental allergies (e.g., pollen, bee stings): _____

Does the student carry an EpiPen? ☐ Yes ☐ No

4. Chronic Conditions / Ailments

☐ Asthma

☐ Diabetes

☐ Epilepsy or seizures

☐ Heart condition

☐ ADHD

☐ Other (please explain): _____

☐ None

Is medication required during school/sports hours? ☐ Yes ☐ No

If yes, explain: _____

Physician Information

- **Primary Care Physician Name:** _____
- **Phone Number:** _____
- **Preferred Hospital:** _____

Parent/Guardian Authorization

I certify that the above information is accurate and complete to the best of my knowledge. I authorize school personnel and coaches to take appropriate action in case of a medical emergency.

Signature of Parent/Guardian: _____
Date: ____ / ____ / _____
