CAROLINA ATHLETIC ASSOCIATION FOR SCHOOLS OF CHOICE
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CAASC ATHLETIC PHYSICAL FORM

Special Note: No other forms are acceptable unless Section II is modified or substituted ONLY to comply with local and/or state laws or because of medical practitioner regulations (medical practice insists on its own form). In either case, Section I must still be filled out entirely and attached to modified/substituted form. Section II must be completed in its entirety ONLY by a Licensed State Examiner (medical doctor, nurse practitioner, etc.)

SECTION I: FOR PARENT OR GUARDIAN COMPLETION ONLY

Legal Name of Participant (Must match birth certificate)

Last _____ First _____ Middle _____

Address: _____ City: _____State:_____Zip:_____

Telephone: _____ Date of Birth: _____ BIRTH SEX: _____Male _____Female

Name of Primary Medical Insurance Company: _____Policy Number: _____

Member Number _____ Name of Primary Insured: _____

PARTICIPANT MEDICAL HISTORY

1.	Are there any injuries requiring medical attention?	Yes	No
2.	Are there any surgeries or scheduled surgeries?	Yes	No
3.	Is there any history of concussions and/or head injuries?	Yes	No
4.	Is the participant currently under the care of a medical practitioner?	Yes	No
5.	Is the participant currently taking any medications?	Yes	No
6.	Does the participant have any allergies?	Yes	No
7.	Does the participant use an inhaler?	Yes	No
8.	Is the participant diabetic/require medication for diabetes?	Yes	No
9.	Does the participant carry sickle cell trait/suffer from sickle cell disease?	Yes	No
10.	Does the participant currently require any medication?	Yes	No
11.	Does/has the participant have/had seizures?	Yes	No
12.	Does the participant wear glasses or contact lenses?	Yes	No
13.	Does the participant wear a brace or other medical support device?	Yes	No
14.	Does the participant have any other physical limitations or medical conditions?	Yes	No

If you answered yes to any of the above questions, please provide the question number and a brief explanation in the following space or attach to this form: _____

I hereby certify that this information is accurate to the best of my knowledge. I acknowledge that it is my responsibility to inform my child's coach or school official in writing if there is a change in the medical condition of my child. I also understand it is my responsibility to obtain written permission from my child's medical provider for my child to resume participation after any injury, illness or accident.

Signature of Parent or Legal Guardian _____Date: _____

SECTION II: THIS SECTIONS MUST BE COMPLETED BY A LICENSED MEDICAL PROFESSIONAL

HEIGHT _____ WEIGHT _____ EYES _____ EARS _____

MOUTH _____ NOSE AND THROAT _____ RESPIRATORY _____

CARDIOVASCULAR _____ NEUROLOGICAL _____ MUSCULOSKELETAL _____

DERMATOLOGICAL _____ BLOOD PRESSURE _____

I hereby certify that I am a licensed state examiner and have examined the above named individual and understand that he/she will be involved in participating in the CAASC athletic programs. I attest that this individual is physically fit and have found no medical reason which would prevent this individual from safely participation in the CAASC sponsored activities for the 20 ____/20 ____ season. I am therefore clearing this individual for athletic participation without limitations.

SIGNATURE OF ATTENDING MEDICAL PROFESSIONAL _____

Printed Name _____

Date _____