This form must be completed and returned DIRECTLY to the Athletic Office PRIOR to Participation in sports including PRACTICE.

NJCAA
MEDICAL EVALUATION FORM
PART I

To be **completed by student** and submitted to the examining physician **before** he/she examines the student.

Student: ______________________________________ Parent: ________________________
Last First Middle

D.O. B. ________________ Address: ____

Phone(s): ______________________________________ School: ___________________________

PERSONAL HEALTH OF STUDENT:

	Check Correct Reply: Yes	No
1. Has had injuries or accidents requiring medical attention?……………………………………		
2. Has had a surgical operation? ………………………………………………………………		
3. Has been in a hospital? ……………………………………………………………………		
4. Has had sickness lasting longer than one week? ………………………………………..		
5. Takes medicine now or regularly? …………………………………………………………		
6. Has a condition now under a physician's care? …………………………………………		
7. Any defect of hearing or eyesight? Wear glasses, contact lenses?………………………..		
8. Any reason this student should not take part in any sport?..		

9. If "YES" to any question, please explain here with names and dates:

____
____
____
____

	Yes	No
10. Has had complete poliomyelitis immunization by injections or vaccine by mouth? ……...		
11. Has had tetanus toxoid and booster inoculation within the past 3 years?......................		
12. Has seen a dentist within the past 6 months? …………………………………………..		
13. To my knowledge the paired organs that follow are present and healthy:		
Eyes………………………………………………………………………………		
Ears (Hearing) …………………………………………………………………..		
Lungs ……………………………………………………………………………		
Kidneys ………………………………………………………………………….		
Testicles or Ovaries …………………………………………………………….		
Arms/Legs ………………………………………………………………………		
Fingers/Toes ……………………………………………………………………		

14. If "NO" to any questions, please explain here with names and dates:

____
____
____
____
____

If a tetanus booster is indicated, I give my permission for such an inoculation to be administered by the examining physician.

Student Athlete's Signature: ________________________________ **Date** ______________

Parent Signature (If Under 18): ________________________________ **Date** ______________

To be completed by physician

Your physician may fax or email your physical form instead of using Medical Evaluation Form Part II

NJCAA
MEDICAL EVALUATION FORM
PART II

Student: ____ Age: ______ Sex: ________
Last First Middle

Significant Past Illness or Injury: ____
____
____
____

Physical Examination: (Check abnormal findings and explain below):

Height: _________ Weight: __________ Blood Pressure: ___________ Pulse Rate: _____________

Eyes: ____________________ Visual Acuity R _____/______; L _____/______

Ears: ____________________ Hearing: R _____/______; L _____/______

Nose (Deformities): ____________________

Oropharynx __________________

Teeth (Caries, Dentures, Braces): ______________

Respiratory: __________________

Breasts: _____________________

Cardiovascular (pedal pulses): ________________

Abdomen (hernia, spleen, liver): ________________

Genitalia and anus: _________________________

Neuromuscular: ____________________________ Skin: _______________________

Spine (cervical, thoracic, lumbar) ____

Extremities (special attention knees, ankles): _________________________________

Laboratory:

Urinalysis: Protein ____________
Sugar ____________
Other ____________

*** Tuberculin Test** ____________
OR
*** Chest X-Ray (Result/Date)**

____
*** If ordered by physician**

Physician's explanation of abnormal findings: ____
____
____

I have **on this date** personally examined this pupil, reviewed the history and other data recorded on both sides of this form and find this pupil physically able to compete in supervised activities listed here **NOT CROSSED OUT**:

Basketball Golf Swimming Wrestling (Minimum Weight) ________ Baseball Gymnastics Tennis
Cross Country Lacrosse Track Football Soccer Softball Other ________________

________________________________ ____________________________________ ________________
Physician's Signature **Physician's Address** **Date**