Carolina Athletic Association for Schools of Choice
PO Box 842, Oak Ridge, NC, 27310
Phone: 336-558-0217 Email: caasc.office@gmail.com

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 (i.e. the medical practice insists on its own form). In either case, Section I must still be filled out entirely and attached to any 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/GUARDIAN COMPLETION ONLY

Legal Name of Participant (must match birth certificate):

Last _____First_____Middle_____

Address:_____City:_____ State: _____Zip:_____

Telephone No:_____ Date of Birth: _____ Male____ Female ____

Name of Primary Medical Insurance Company:_____Policy Number:_____

Membership Number:_____Name of Primary Insured: _____

Does primary insured have Medicaid? Yes No Does primary insured have Medicare? Yes No

Sport (check one): Cheer_____ Dance_____ Tackle_____ Flag_____

PARTICIPANT MEDICAL HISTORY

1.	Are there any injuries requiring medical attention?	Yes	No
2.	Are there any past 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 (penicillin, bee stings, etc)?	Yes	No
7.	Does the participant have asthma/require the use of 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 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 an explanation in the following space and/or attach to this form: _____
_____
_____
_____

I hereby certify that this information is accurate to the best of my knowledge. I understand that this medical authorization may be voided in the event of injury, illness or accident and my child may not be cleared for participation at such time. Furthermore, I hereby acknowledge that it is my responsibility to inform my child's coach or school official in writing if there is any change in the medical condition of my child. I also understand that it's my responsibility to obtain written permission from my child's physician on official medical stationary in order to seek permission for my child to resume participation after any and all such injury, illness or accident.

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Signature of Parent or Legal Guardian: _____

Print Name_____

Relationship to Participant_____

Dated_____

Section II: THIS SECTION MUST BE COMPLETED ONLY BY A LICENSED MEDICAL PROFESSIONAL.

Name of Participant:_____
(Please check the following if healthy or note otherwise):

Height	Weight	Eyes
Ears	Mouth	Nose & 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 hereby swear and attest that this individual is physically fit and I have found no medical reason which would prevent this individual from safely participating in The CAASC sponsored activities for the 20___ - 20___ season. I am therefore clearing this individual for athletic participation without limitation.

Please indicate medical profession (M.D., D.O. R.N., etc.)_____

Are you licensed in the state of North Carolina to perform physical examinations? YES NO

Dated: _____

Please sign and fill out the following information OR place Official Medical Practice Stamp here:

Signature_____ Printed Name_____

Address_____City_____State_____ Zip_____

Phone _____ Fax: _____

Email/Website:Email_____ (Optional)

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