Christian Academy of Madison

PARTNER · PROVIDE · PROMOTE · PREPARE

477 West Hutchinson Lane • Madison, Indiana 47250 • (812) 273-5000 • caofmadison@gmail.com • www.camdefenders.com

PHYSICAL EXAMINATION

Student name: _____ Gender: M F Date of Birth: _____/_____/_____
Father's Name: _____ Work phone / cell phone: _____/_____
Mother's Name: _____ Work phone / cell phone: _____/_____
Street address: _____
City: _____ State: _____ Zip Code: _____ Home phone: _____
Emergency Contact Person: _____ Relationship: _____ Phone: _____
Physician's name: _____ Address: _____ Phone: _____

Height_____ Weight_____ Vision: R _____ L_____ BP_____ HR_____
R_____ T_____ Eyes_____ Ears_____ Nose/Throat_____
Neck _____ Lungs _____ Cardiovascular _____
Chest & Lungs _____ Abdomen _____ Genitalia/Hernia _____
Skin/Birthmarks_____ Musculoskeletal System _____
Neuromuscular _____ Speech _____ U/A _____
Comments and Recommendations_____
_____

Physician Signature _____ Date _____

STUDENTS IN 1st-12TH GRADE WHO PLAN TO PARTICIPATE IN SPORTS AT CAM

1.	Has anyone in the athlete's immediate family died suddenly before age 50?	YES	NO	Don't Know
2.	Has the athlete ever stopped exercising because of dizziness or passed out during exercise?	YES	NO	Don't Know
3.	Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise?	YES	NO	Don't Know
4.	Has the athlete ever had a broken bone, had to wear a coast, or had an injury to any joint?	YES	NO	Don't Know
5.	Does the athlete have a history of concussion (getting knocked out)?	YES	NO	Don't Know
6.	Has the athlete ever suffered a heat-related illness (heat stroke)?	YES	NO	Don't Know
7.	Does the athlete have a chronic illness or see a doctor regularly for any particular problem?	YES	NO	Don't Know
8.	Does the athlete take any medications?	YES	NO	Don't Know
9.	Is the athlete allergic to any medications or bee stings?	YES	NO	Don't Know
10.	Does the athlete have only one of any paired organs (eyes, ears, kidneys, testicles, ovaries)?	YES	NO	Don't Know
11.	Has the athlete had any injury in the last year that caused him/her to miss 3 or more consecutive days of practice or competition?	YES	NO	Don't Know
12.	Has the athlete had surgery or been hospitalized in the past year?	YES	NO	Don't Know
13.	Has the athlete missed more than 5 consecutive days of participation in usual activities because of illness, or has the athlete had a medical illness diagnosed that has not been resolved in the past year?	YES	NO	Don't Know
14.	Are you, the athlete, worried about any problem or condition at this time?	YES	NO	Don't Know

"Study to show thyself approved unto God, a workman that needeth not to be ashamed, rightly dividing the word of truth." --2 Timothy 2:15

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Please give details on any "YES" answer from the above health history.

_____

_____

I certify that I have examined this athlete and found him/her medically qualified to participate in sports. I also certify that I am a licensed medical physician, physician's assistant, or family nurse practitioner. (Doctor of Chiropractic Medicine is not satisfactory.)

Participation Restrictions: _____

_____

_____

Physician Signature: _____ Date: _____

IMMUNIZATION RECORD

Indiana State Law requires all children to be immunized for Diptheria, Pertussis, Tetanus, Polio, Measles, Mumps, and Rubella. It is also required for students entering kindergarten to be immunized for Chicken Pox and Hepatitis B and for students entering sixth grade to be immunized for meningococcal disease. The State requires that a birth certificate and immunization record must be on file with the school **no later than 30 days** from the date of enrollment. Our school requires all new students to have a complete physical examination and recommends that other students have one as well.

Please obtain a copy of student's immunizations from the doctor or health department. If student has not received immunizations due to objections, please read the following paragraphs and answer the questions that follow.

Indiana Law, (Public Law 103, amending IC 20-8.1-7-2) although requiring immunization of children in public schools, states also that: except as otherwise provided, a school child may not be required to undergo any testing, examination, immunization, or treatment required under this chapter when the child's parent objects on religious grounds. A religious objection does not exempt a child from any testing, examination, immunization, or treatment required under this chapter unless the objection is:

1. Made in writing;
2. Signed by the child's parent; and
3. Delivered to the child's teacher or to the individual who might order a test, an exam, an immunization, or a treatment absent the objection.

Indiana Law, (Public Law 103, amending IC 20-8.1-7-2.5) exception for child's health states that: if a physician certifies that a particular immunization required by this chapter is or may be detrimental to the child's health, the requirements of this chapter for that particular immunization is inapplicable for that child until it is found no longer detrimental to the child's health.

In order for a child to be exempted from complying with minimum immunization requirements for medical or religious reasons, the parent or guardian is required to submit a written request for exemption and the request must be filed **annually** with the school corporation. In the case of a medical exemption, the signature of a physician is required **annually.** Parental or medical exemptions do not relieve parents from the responsibility of reporting a record of immunizations that have already been given.

I object to immunization being given to my child, _____, as required by Public Law 103 concerning health measures for children.

*PLEASE MARK EITHER RELIGIOUS OR MEDICAL OBJECTION BELOW. (**A MEDICAL EXEMPTION MUST HAVE A PHYSICIAN SIGNATURE**):*

Religious objection ☐ ***(check if applicable)***

Parent/Guardian Name: _____

Parent Signature: _____ Date: _____

Medical objection ☐ ***(check if applicable)***

I, *(Physician name printed)* _____, certify that receiving *(particular immunization)* _____ is or may be detrimental to this child's health.

Physician's Signature: _____ Date: _____

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