NJCAA
Medical Evaluation Form
Part 1

TO BE COMPLETED BY THE STUDENT AND SUBMITTED TO THE EXAMINING PHYSICIAN BEFORE HE EXAMINES THE STUDENT:

Student_____ Parent_____
Last First Middle

Date of Birth_____ Address_____

School **Gordon College, Barnesville GA** Phone **(678) 359-5061**

PERSONAL HEALTH OF STUDENT Circle correct reply:

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

If **"YES"** to any question, explain here with names and dates_____

_____

_____

9. Has had complete poliomyelitis immunization by injections (Salk) or vaccine by mouth (Sabin) . . . . . yes no
10. Has had tetanus toxoid and booster inoculation within the past three years . . . . . yes no
11. Has had a dental examination within the past 6 months . . . . . yes no
12. To my knowledge the paried organs that follow are present and healthy:
    - Eyes . . . . . yes no
    - Ears (hearing) . . . . . yes no
    - Lungs. . . . . yes no
    - Kidneys. . . . . yes no
    - Testicles or ovaries. . . . . yes no
    - Arms/Legs. . . . . yes no
    - Fingers/Toes. . . . . yes no

If **"NO"** to any questions, 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.

_____
Signature of Student

NJCAA
MEDICAL EVALUATION PART II
(TO BE COMPLETED BY PHYSICIAN)

Name of Student_____Age_____ Sex_____
Last First Middle
Significant Past Illness or Injury_____

_____

Physician's Examination: (Check abnormal findings and explain below)
Height_____ Weight_____ Blood Pressure _____ Pulse Rate_____
Eyes_____ Visual Acuity R_____/_____; I_____/_____
Ears_____ Hearing R_____/_____; I_____/_____
Nose_____(deformities) _____
Oropharynx _____

Teeth (caries, dentures, braces)_____
_____Respiratory_____
_____Breast_____
_____Cardiovascular (pedal pulses)_____
_____Abdomen (hernia, spleen, liver) _____
_____Genitalia and anus_____
_____Neuromuscular_____Skin_____
_____
_____Spine (cervical, thoracic, lumbar)_____
_____Extremities (special attention to knees, ankles)_____

Physician's explanation of abnormal findings:_____

_____

_____

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

Basketball	Golf	Swimming	Wrestling
Baseball	Gymnastics	Tennis	Minimum Weight_____
Cross Country	Lacrosse	Track	Other_____
Football	Soccer		_____

_____M. D._____
Physician's Signature Address

_____M. D._____ _____
Physician's Name Typed Date of Examination Physician's Phone Number