

# Central Maryland Christian Crusaders

## Medical Evaluation for participation in Cheerleading

**Part 1:** To be completed by Parent or Guardian and submitted to the physician before the physical exam.

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

List all known pre-existing conditions, prior injuries or congenital problems: \_\_\_\_\_

\_\_\_\_\_

List all known allergies: \_\_\_\_\_

Medications currently taking: \_\_\_\_\_

Wears contacts: Yes      No

Insurance Provider: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Part 2:** To be completed by the examining physician:

Examining Physician: \_\_\_\_\_ Physical Examination Date: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

Identify if normal or abnormal, please explain any abnormal findings:

Vision: \_\_\_\_\_ Hearing: \_\_\_\_\_

Oropharynx: \_\_\_\_\_ Respiratory: \_\_\_\_\_

Neuromuscular: \_\_\_\_\_ Cardiovascular: \_\_\_\_\_

Spine: \_\_\_\_\_ Skin: \_\_\_\_\_

Additional explanations of abnormal findings: \_\_\_\_\_

\_\_\_\_\_

I have examined the student, reviewed the above history,  
and find her physically able to participate in all aspects of cheerleading for the season of 20\_\_\_\_\_.

Physician Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_