



## NLCAH Elementary (PK-Kinder) Registration Checklist for New Students

In the spirit of Christian unity and the love that Christ shows for all mankind, New Life Christian Academy Hybrid (NLCAH) does not discriminate on the basis of race, age, national origin, or physical disability. However, NLCAH does reserve the right to use appropriate selection criteria in fulfillment of its goals and objectives for student enrollment.

Date \_\_\_\_\_ Student's Full Name \_\_\_\_\_ Grade Entering \_\_\_\_\_ Age \_\_\_\_\_

All items **must be submitted** to the Registrar's Office **before** an Entrance Exam is scheduled.

1. Student Enrollment Application \_\_\_\_\_
2. Enrollment Questionnaire \_\_\_\_\_
3. Teacher/Daycare Recommendation Form \_\_\_\_\_
4. Immunization Records \_\_\_\_\_
5. Physical Form \_\_\_\_\_
6. Copy of SS card \_\_\_\_\_
7. Copy of Birth Certificate \_\_\_\_\_
8. Student Emergency Authorization \_\_\_\_\_
9. Legal Documents (applicable) \_\_\_\_\_
10. Copy of Parent(s)' or Legal Guardians' ID \_\_\_ Dad \_\_\_ Mom
11. Application Fee \_\_\_\_\_ Date Payment Received \_\_\_\_\_
12. Copy of Transcript \_\_\_\_\_  
*Date of request:* \_\_\_\_\_ *Date received:* \_\_\_\_\_
13. Interview Date: \_\_\_ - \_\_\_ - \_\_\_ Interviewer: \_\_\_\_\_ Accepted:  Yes  No  
 Probation:  Yes  No If yes, please explain \_\_\_\_\_  
 \_\_\_\_\_
14. Registration Payment made to Finance Officer  
 Date Payment Received: \_\_\_\_\_ Received by: \_\_\_\_\_
15. Graduation Date: \_\_\_\_\_ Withdrawal Date: \_\_\_\_\_

Checklist should be placed in student's file upon the completion of all items

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NEW LIFE CHRISTIAN ACADEMY **HYBRID**  
NEW STUDENT ENROLLMENT APPLICATION

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**Section 1: STUDENT INFORMATION**

Date: \_\_\_\_\_ School Year: \_\_\_\_\_ to \_\_\_\_\_ Grade Entering: \_\_\_\_\_  
Legal Name: \_\_\_\_\_ "Goes By" \_\_\_\_\_  
SSN: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Gender: M F Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Please Check One:       Asian / Pacific       Afro-American  
                                  Caucasian       Hispanic       Other \_\_\_\_\_  
Student's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Student's Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_  
Hospital Preference: \_\_\_\_\_

**Section 2: PARENTAL INFORMATION** (Please complete for legal guardians with whom the child lives)

Parent's Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home #: \_\_\_\_\_ His Cell #: \_\_\_\_\_ Her Cell #: \_\_\_\_\_  
His Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work # \_\_\_\_\_  
Her Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work # \_\_\_\_\_  
His Email: \_\_\_\_\_ Her Email: \_\_\_\_\_  
Marital Status:     Single     Married     Divorced     Widowed     Separated

**Section 3: STUDENT PICK UP / EMERGENCY CONTACT**

Please list the names of the individuals authorized to pick up your child from School.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Section 4: REFERRAL INFORMATION**

Who may we thank for referring you to NLCAH?    \_\_\_ Radio    \_\_\_ Internet    \_\_\_ Advertisement  
\_\_\_ Friends/Family    \_\_\_ Current Student ( \_\_\_\_\_ )    \_\_\_ Other \_\_\_\_\_

**Section 5: SCHOOL RECORD INFORMATION**

How many schools/daycares has student attended: \_\_\_\_\_ Home Schooled:  Yes  No

How many schools did child attend this past year: \_\_\_\_\_ From: \_\_\_\_\_ to \_\_\_\_\_

Name of last school attended: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Section 6: PERMISSION FOR DISCIPLINARY MEASURES**

The school administrators are responsible for maintaining an orderly discipline in the Academy for the progress and welfare of each student. It may become necessary to discipline a student for his/her misconduct or misbehavior by mildly spanking him/her. I agree with this policy and give my permission to the Superintendent and the Principal to use mild spanking should it become necessary.

**Section 7: PERMISSION FOR PARTICIPATION IN SCHOOL ACTIVITIES**

I give my permission for my child to participate in all school activities, including school sponsored trips away from school premises. I absolve the school from liability due to injury or accidents while my child participates in these activities and trips.

**Section 8: POLICY AGREEMENT REGARDING REFUNDS**

In submitting the Application for Enrollment, it is my desire for my child to complete this school year. It is also my understanding that the school policy is that refunds are not given for registration or any other fees.

**STATEMENT OF FAITH**

We believe the Bible is the inspired Word of God and Divine revelation of Jesus Christ, God’s son. We believe in the Trinity of the God-Head, the Father, the Son, and the Holy Spirit. We believe that Jesus Christ was born of a virgin; walked upon and ministered on the earth, died the death of the cross; arose from the dead; and is now seated at the right hand of God. We believe that man’s only salvation is through the recognition of the Lordship of Jesus and the acceptance of Him as Lord and Savior. We believe that Jesus Christ has sent the Comforter, in the person of the Holy Spirit and that we may be infilled by Him and speak in other tongues as He gives us the utterance as recorded in God’s Word. We believe in the gifts of the Spirits as expressed in I Corinthians chapters 12-14, being manifested in the local church. We believe in water baptism by immersion after accepting Jesus as Lord and Savior. We believe in celebration of the Lord’s Supper in remembrance of our Lord, Jesus Christ. We believe in the total substitutionary sacrifice of Jesus – He was made poor that we might be made rich. We believe that God is our answer, not our problem, and that He does not use sickness, disease, test, trials, nor tragedy to teach his children but instead uses His word to instruct us in the ways of righteousness. We believe in the second coming of Jesus Christ and that we, as members of His body, shall reign together with Him. We believe in conducting our business and personal lives in a manner that will not bring dishonor or reproach to the name of Jesus. We believe in the building up of the Body of Christ through the assembling of ourselves together for fellowship and the teaching of God’s Word.

“For other foundation can no man lay than that is laid, which is Jesus Christ” I Corinthians 3:11

**I have read, understood, and consent to the above permissions. I have also read and agree with the School’s statement of faith. I affirm that all information on this application is true and up to date, and I will notify the school of any changes. I understand that incorrect information may lead to administrative dismissal.**

\_\_\_\_\_

**SIGNATURE** **DATE**

NEW LIFE CHRISTIAN ACADEMY **HYBRID**  
ENROLLMENT QUESTIONNAIRE PK-Kinder

**Date:** \_\_\_\_\_ **Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

*In regards to your child, please check the correct answer and answer all questions truthfully.  
Inaccurate, or falsified, information may lead to your child's dismissal from the Academy.*

**For all questions in which a "Yes" is checked, please provide details below.**

1. Has your child ever been recommended for special education?  Yes  No
2. Has your child ever been held back or not promoted to the next grade?  Yes  No
3. Has your child ever been placed under child protective custody?  Yes  No
4. Has your child ever been suspended or expelled from daycare/school?  Yes  No
5. Has your child ever been sent to an alternative (disciplinary) school?  Yes  No
6. Is your child on prescribed or maintenance medication?  Yes  No
7. Has your child ever been diagnosed as Attention Deficit or Hyperactive?  Yes  No
8. Has your child ever been in trouble with daycare/school for behavioral issues?  Yes  No
9. Does your child have any issues with using the restroom on his/her own?  Yes  No
10. Does your child have any special/medical needs?  Yes  No

Please provide details for all above "Yes" boxes:

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I certify that I am the legal parent/guardian of the student named on this questionnaire and that I have answered all questions truthfully to the best of my knowledge. I understand that information intentionally withheld may result in my child's dismissal from the Academy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## CONFIDENTIAL TEACHER RECOMMENDATION FORM

Applicant should complete this section and then give this form to the Daycare Facilitator/Teacher or other authorized personnel.

Applicant's Name \_\_\_\_\_ Grade Entering \_\_\_\_\_ DOB \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

**The above named student has applied for admission to New Life Christian Academy Hybrid. In order to make an intelligent selection of students and to adequately meet their needs, we must obtain as much information as possible before he/she comes to us. We ask that you complete this form only answering the questions about which you have knowledge. The information you give will be kept in strict confidence. Once completed please mail or fax to:**

New Life Christian Academy Hybrid  
6622 Highway 90 West  
San Antonio, TX 78227  
210-679-6080 (Fax)

Name of School \_\_\_\_\_ Name of Teacher (print) \_\_\_\_\_

In what capacity and for how long have you known the applicant? \_\_\_\_\_

Please indicate your rating by numbers in the right-hand column. Use a question mark where you have insufficient evidence.

	5	4	3	2	1	RATING
ACADEMIC ABILITY	Exceptional	Above Average	Average	Lower Marginal Ability	Poor Academic Risk	
INITIATIVE, DRIVE	Outstanding takes the initiative	Above Average Needs little direction	Average	Occasionally weak or lacking	Very Weak	
LEADERSHIP & RESPONSIBILITY	Highly Respected, Well Liked	Influential & Respected	Accepted, but not sought out	No signs of leadership or involvement	Irresponsible	
ACHIEVEMENT	Outstanding Promotes Involvement	Commendable Team-player	Active	Minor Participation	No Participation	
PARENTAL SUPPORT	Exceptional	Very Good	Average	Sometimes Unsupportive	Very Unsupportive	
PEER RELATIONSHIPS	Respected, Good choices in friends	Respected & Liked	Sociable, Influenced by peers	Makes sociable contact	Unsociable	
CHARACTER	Completely trustworthy	Dependable	Exhibits some deceptions	Dishonest	Untrustworthy	
EMOTIONAL STABILITY	Extremely Well Balanced	Well Balanced	Usually No Problems	Some Problems	Highly Emotional	
SUMMARY AS A PERSON	Outstanding	Above Average	Average	Below Average	Poor	

Do you recommend this student to attend New Life Christian Academy Hybrid?    Yes    No    Reservation \*

Teacher's Signature \_\_\_\_\_ Date \_\_\_\_\_

## PASTORAL RECOMMENDATION FORM

Please complete Section 1, and then send the form to their Pastor to fill out Section 2.

### SECTION 1.

Name _____			
Address _____	City _____	State _____	Zip _____
Home Phone(____) _____	Work Number(____) _____	Cell Number(____) _____	
Place of Church Membership _____		Phone Number _____	
Pastor's Name _____			

### SECTION 2.

TO BE FILLED OUT BY THE PASTOR (CONFIDENTIAL)

Your recommendation is important. Once completed, please return this form to New Life Christian Academy Hybrid, 6622 Hwy 90W, San Antonio, TX 78227. You may FAX the completed form to the Admission office at (210) 679-6080

Member of the Church	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Financially supports the church	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
How regularly does the student and his/her family, attend worship services? _____			
_____			
Please check the all areas that this individual or family is active in your church.			
____ Choir or Music Ministries	____ Youth Ministry	____ Bible Study	____ Children's Ministry
____ Sunday School Teacher/Worker	____ Outreach Ministries	____ Other _____	
How well do you know this individual/family? _____			
_____			

Pastor's Name (Print) \_\_\_\_\_ Date \_\_\_\_\_

Pastor's Signature \_\_\_\_\_ Date \_\_\_\_\_



**NEW LIFE CHRISTIAN ACADEMY HYBRID**

6622 Highway 90 West  
San Antonio, Texas 78227

Phone: 210.679.6001 Fax: 210.679.6080

www.newlifehybrid.com

<b>Student Information</b>	_____ - _____ School Year	_____ Grade	_____ M	_____ F	____/____/____ Date of Birth
	Legal Name _____				
Home Address _____					
Street		City	State	Zip	

<b>Parent/Guardian Information</b>	A telephone number where a parent/guardian can be reached in case of emergency is required			
Father/Legal Guardian _____	Place of Employment _____			
Home Phone (____) _____	Business Phone (____) _____	Cell Phone (____) _____		
Mother/Legal Guardian _____	Place of Employment _____			
Home Phone (____) _____	Business Phone (____) _____	Cell Phone (____) _____		
Please list names of other adults who are authorized to pick up your student and make important decisions if necessary.				
Adult #1	Relationship	(____) _____ Home Phone	(____) _____ Work Phone	(____) _____ Cell Phone
Adult #2	Relationship	(____) _____ Home Phone	(____) _____ Work Phone	(____) _____ Cell Phone

**Medical Information**

Please complete the following. Unless otherwise restricted by law, special health problems will be shared with appropriate staff and faculty to provide the best possible care for your student. Check all that apply.

Student Physician \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Telephone \_\_\_\_\_

New Life Christian Academy Hybrid does not assume any financial responsibility, but will provide or arrange emergency care. By signing this card you are giving the appropriate school personnel authority to call EMS, to transport, or to obtain medical care if you or the alternate adult cannot be reached.

**CONDITION**

List any other health condition that would be significant in the care of your child at school.

Asthma

Diabetes

Is child taking medication?

Yes  No  If yes, please specify

Epilepsy/Seizure Disorder

Date of last

Heart: Type of condition

Allergies – Type (Food, Insect, Other)

Reaction: Mild  Severe

Updated Immunizations: Yes  No

If yes when:

Epipen: Yes  No

Vision: Glasses  Contacts  Visual Impairment: \_\_\_\_\_

Has child had a hearing test: Yes  No  If yes, when? \_\_\_\_\_

I hereby grant permission for emergency care to be given by the attending physician and/or school personnel. I also give permission for EMS to be called and/or my child to be transported as necessary by school personnel. I will NOT hold New Life Christian Academy Hybrid financially responsible for the emergency care and/or transportation of my child.

Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_



**PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY**

REVISED 10-18-07

This **MEDICAL HISTORY FORM** must be completed *annually* by parent (or guardian) and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

Student's Name: (print) \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Grade \_\_\_\_\_ School \_\_\_\_\_

Personal Physician \_\_\_\_\_ Phone \_\_\_\_\_

*In case of emergency, contact:*

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

Explain "YES" answer in the box below \*\*. Circle the questions to which you do not know the answers. Any YES answer to questions 1,2,3,4,5 or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in TAPS practices, games or matches.

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you ever gotten unexpectedly short of breath with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized overnight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, check appropriate box and explain below.		
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip		
Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh		
Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome, or abnormal heart rhythm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee		
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Shin/Calf		
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Ankle		
4. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper Arm <input type="checkbox"/> Foot		
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many _____ When was the last _____			Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
times? _____ concussion?			17. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
How severe was each one? (Explain below)			18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	<i>Females Only</i>		
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	19. When was your first menstrual period?	_____	
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>	When was your most recent menstrual period?	_____	
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	How much time do you usually have from the start of one period to the start of another?	_____	
5. Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>	How many periods have you had in the last year?	_____	
6. Are you under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>	What was the longest time between periods in the last year?	_____	
7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>			
8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question three above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner.</b>		
9. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<b>**EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):</b>		
10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
11. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
12. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	_____		

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the school assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL**

Student Signature: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.**

**PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION**

Student's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_/\_\_\_\_ (\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_)  
 Vision R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

As a minimum requirement, this **Physical Examination Form** must be completed prior to junior high athletic participation and again prior to first and third years of high school athletic participation. It **must** be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side. *\* Local district policy may require an annual physical exam.*

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position.			
Heart-Auscultation of the heart in the standing position.			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

\*station-based examination only

**CLEARANCE**

- Cleared
- Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_  
 \_\_\_\_\_
- Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_
- Recommendations: \_\_\_\_\_  
 \_\_\_\_\_

*The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.*

Name (print/type) \_\_\_\_\_ Date of Examination: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 Signature: \_\_\_\_\_

Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or games/matches.