



Crown Point Christian School Athletics

Form D

Physical Form

Student Information:

Name: _____

Date: _____

Address: _____

Date of Birth: _____

0 = No Defect

√ = Slight Defect

X = Marked Defect

Required	Recommended
Height	Urine
Weight	Tonsils
General Posture	Nose and Throat
Heart	Eyes
Lungs	
Orthopedic	In the space below, indicate any athletic activities in which student should not participate
Contagion	

Physician's Signature

Date

Crown Point Christian School
10550 Park Place
St. John, IN 46373
219-365-5694
219-365-5729 Fax

Signed for 2014/15 School Year