PART I – CONSENT AND EMERGENCY INFORMATION

I hereby give permission for my child, _____, to participate in _____. Further, I authorize the school to provide emergency treatment of any injury or illness my child may experience if qualified medical personnel consider treatment necessary and perform the treatment. This authorization is granted only if I cannot be reached and a reasonable effort has been made to do so.

Date _____ Parent or Guardian (Print) _____

Address _____ Phone _____

Athlete's Name _____ DOB _____

Address (if different from above) _____

Phone _____ SSN _____

List two persons to contact in case of emergency:

1. Print Name _____ Phone _____

Relationship to Athlete _____

2. Print Name _____ Phone _____

Relationship to Athlete _____

Family Physician (Name and Phone) _____

Does the student have (check any that apply): Asthma ____ Diabetes ____ Epilepsy ____

Does the student have any other medical conditions? (Is so, please specify) _____

_____

List any current medications _____

List any allergies to medications _____

Does the student wear contacts? Yes ____ No ____

Parent Signature _____ Date _____

PART II - - MEDICAL HISTORY- Explain "Yes" answers below

This form must be completed and signed, prior to the physical examination, for review by examining practitioner. Explain "Yes" answers below with number of the question. Circle questions you don't know the answers to.

GENERAL MEDICAL HISTORY	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you currently have an ongoing medical condition? If so, Please identify: Asthma Anemia Diabetes Infections Other:		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, or pressure in your chest during exercise?		
7. Does your heart race or skip beats during exercise?		
8. Has a doctor ever told you that you have (check all that apply): High Blood Pressure A heart murmur High cholesterol A heart infection Kawasaki disease Other:		
9. Has a doctor ever ordered a test for your heart? (For ex: ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
12. Has any family member or relative died of heart problems or had an unexpected sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?		
13. Does anyone in your family have a heart problem?		
14. Does anyone in your family have a pacemaker or implanted defibrillator?		
15. Does anyone in your family have Marfan syndrome, cardiomyopathy, or Long Q-T?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?		
18. Have you had any broken or fractured bones or dislocated joints?		
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?		
20. Have you ever had an x-ray of your neck for atlanto-axial instability? OR Have you ever been told that you have that disorder or any neck/spine problem?		
21. Have you ever had a stress fracture of the bone?		
22. Do you regularly use a brace or assistive device?		
23. Do you currently have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have a history of juvenile arthritis or connective tissue disease?		
MEDICAL QUESTIONS	**Yes**	**No**
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Do you have asthma or use asthma medicine (inhaler, nebulizer)		
28. Were you born without or are you missing a kidney, an eye, a testicle, spleen or any other organ?		

MEDICAL QUESTIONS (continued)	Yes	No
29. Do you have groin pain or a painful bulge or hernia in the groin area?		
30. Have you had mononucleosis (mono) within the last month?		
31. Do you have any rashes, pressure sores, or other skin problems?		
32. Have you ever had a herpes or MRSA skin infection?		
33. Are you currently taking any medication on daily basis?		
34. Have you ever had a head injury or concussion? If so, date of last injury:		
35. Have you ever had a numbness, tingling, or weakness in your arms or legs after being hit or falling?		
36. Do you have headaches with exercise?		
37. Have you ever been unable to move your arms or legs after being hit or falling?		
38. When exercising in heat, do you have severe muscle cramps or become ill?		
39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
40. Have you had any other blood disorders?		
41. Have you had any problems with your eyes or vision?		
42. Do you wear glasses or contact lenses?		
43. Do you wear protective eye wear, such as goggles or a face shield?		
44. Do you worry about your weight?		
45. Are you trying to or has any professional recommended that you try to gain or lose weight?		
46. Do you limit or carefully control what you eat?		
47. Do you have any concerns that you would like to discuss with a doctor?		
48. When is the date of your last Tdap or Td (tetanus) immunization? (Circle Type) Date: _____		
49. Do you have an allergy to medicine, food, or stinging insects?		
FEMALES ONLY 50. Have you ever had a menstrual period?		
51. Age when you had your first menstrual period? _____		
52. How many periods have you had in the last 12 months? _____		

EXPLAIN "YES" ANSWERS BELOW:

#____» _____

#____» _____

#____» _____

#____» _____

#____» _____

*List medications and nutritional supplements you are currently taking here:

►► **Parent/Guardian Signature:** _____ **Date:** _____ **Athlete's Signature:** _____

PART III – PHYSICAL EXAMINATION

(Physical examination is required each school year after May 1 of the preceding school year and is good through June 30th of the current school year)**

NAME _____ **Date of Birth** _____ **School** _____

EXAMINATION				
Height	Weight		☐ Male ☐ Female	
BP /	Pulse	Vision R 20/	L 20/	Corrected ☐ Yes ☐ No

MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance		
Eyes/ears/nose/throat		
Lymph nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin		
Neurologic		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional		

Medical Practitioner to School Staff (please indicate any instructions or recommendations here)

Emergency medications required on-site	☐ Inhaler ☐ Epinephrine	☐ Glucagon ☐ Other:

Comments:

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics.

- ☐ **CLEARED WITHOUTRESTRICTIONS**
- ☐ **CLEARED WITH FOLLOWING NOTATION:** _____
- ☐ Cleared **AFTER** documented further evaluation or treatment for: _____
  _____
- ☐ Cleared for **Limited participation** (check and explain "reason" for all that apply): *"Limited Until Date" when appropriate*
  - ☐ Not cleared for (specific sports)_____ Until Date:_____
    Reason(s): _____
- ☐ **NOT CLEARED FOR PARTICIPATION Reason** _____

By this signature, I attest that I have examined the above student and completed this pre-participation physical including a review of Part II – Medical History.

Physician Signature:_____+ (MD, DO, LNP, PA) . Date _____
Circle one

Examiner's Name and degree (print): _____ Phone Number _____

Address:_____City_____State_____Zip _____

+Only signatures of Doctor of Medicine, Doctor of Osteopathic Medicine, Nurse Practitioner or Physician's Assistant licensed to practice in the United States will be accepted.

PART IV -- ACKNOWLEDGEMENT OF RISK AND INSURANCE STATEMENT

(To be completed and signed by parent/guardian)

I give permission for _____(name of child/ward) to participate in any of the following sports that are not crossed out: baseball, basketball, cheerleading, cross country, field hockey, football, golf, gymnastics, lacrosse, soccer, softball, swimming/diving, tennis, track, volleyball, wrestling, other (identify sports). _____

I have reviewed the individual eligibility rules and I am aware that with the participation in sports comes the risk of injury to my child/ward. I understand that the degree of danger and the seriousness of the risk varies significantly from one sport to another with contact sports carrying the higher risk. I have had an opportunity to understand the risk inherent in sports through meetings, written handouts, or some other means. He/she has student medical/accident insurance available through the school (yes__ no__); has athletic participation insurance coverage through the school (yes__ no__); is insured by our family policy with:

Name of Medical Insurance Company: _____

Policy Number: _____ Name of Policy Holder: _____

I am aware that participating in sports will involve travel with the team. I acknowledge and accept the risks inherent in the sport and with the travel involved and with this knowledge in mind, grant permission for my child/ward to participate in the sport and travel with the team.

By this signature, I hereby consent to allow the physician(s) and other health care provider(s) selected by myself or the school to perform a pre-participation examination on my child and to provide treatment for any injury or condition resulting from participating in athletics/activities for his/her school during the school year covered by this form. I further consent to allow said physician(s) or health care provider(s) to share appropriate information concerning my child that is relevant to participation in athletics and activities with coaches and other school personnel as deemed necessary.

Additionally I give my consent and approval for the above named student's picture and name to be printed in any high school or VHSL athletic program, publication or video.

PART V - EMERGENCY PERMISSION FORM

(To be completed and signed by parent/guardian)

STUDENT'S NAME_____ **GRADE**_____ **AGE**_____ **DOB**_____

HIGH SCHOOL_____ **CITY**_____

Please list any significant health problems that might be significant to a physician evaluating your child <u>in case of an emergency</u>

_____

_____

Please list any allergies to medications, etc._____

_____

Is the student currently prescribed an inhaler or Epi-Pen?_____ List the emergency medication: _____

Is student presently taking any other medication? _____ If so, what type? _____

Does student wear contact lenses?_____ Date of last Tdap or Td (tetanus) shot _____

EMERGENCY AUTHORIZATION: In the event I cannot be reached in an emergency, I hereby give permission to physicians selected by the coaches and staff of _____High School to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for the person named above.

Daytime phone number (where to reach you in emergeney) _____

Evening time phone number (where to reach you in emergency) _____

Cell phone _____

☼►►**Signature of parent or guardian** _____ Date_____

Relationship to student_____

*Emergency Permission Form may be reproduced to travel with respective teams and is acceptable for emergency treatment if needed.

I certify all the above information is correct_____

☼►► **Parent/Guardian Signature**

The pre-participation physical examination is not a substitute for a thorough annual examination by a student's primary care physician.