



Athletic Participation/Parental Consent/Physical Examination Form

PART I - ATHLETIC PARTICIPATION

For School Year_____

Male____ Female_____

Name_____

(Last)

(First)

(Middle Initial)

Home Address_____

City/State/Zip Code_____

Date of Birth_____ Place of Birth_____

Students in Grades 6 – 8 only

- Students in Grade 6 must have their immunizations updated to include the required Tdap
- All students who do not participate in sports for more than two days must have a doctor's note
- If student is excused from sports for five or more days, he/she will be given a project to work on.

Students New to Highland School

Parts I, II and IV must be completed. A Commonwealth of Virginia School Entrance Exam form (available at Doctor's offices or on the Highland School web site) must be completed by a doctor and submitted instead of Part III of the Sports Physical.



PART II - MEDICAL HISTORY

This form must be completed by parent or guardian prior to the physical examination and should be taken with the physical examination form for review by the physician during the examination.

1. Have you ever had any of the following? Please explain any YES answers

YES	NO	
___	___	heart murmur _____
___	___	high blood pressure _____
___	___	other heart problems _____
___	___	broken bones _____
___	___	weak joints-ankles, knees _____
___	___	concussion _____
___	___	operation _____
___	___	seizures or epilepsy _____
___	___	2. Have you ever fainted or passed out? _____
___	___	3. Have you ever been knocked out? _____
___	___	4. Have you ever been hospitalized? _____
___	___	5. Have you ever had to stop running after ¼ to ½ miles for chest pain or shortness of breath? _____
___	___	6. A. Have you ever had significant allergies to:
___	___	bee stings? - On medication – yes___ no___ _____
___	___	foods _____
___	___	medicine _____
___	___	others _____
___	___	7. Do you have a prescription for use of:
___	___	Adrenaline _____
___	___	Inhalers _____
___	___	Other allergy medicine _____
___	___	8. Do you have asthma? _____
___	___	9. Do you take any medicine regularly? _____
___	___	10. Have you had any illnesses lasting a week or more such as mononucleosis, etc.? _____
___	___	11. Have you had any blood disorders, including sickle cell trait, anemia, etc.? _____
___	___	12. Has any family member had a heart attack, heart problems or sudden death before the age of 50? _____
___	___	13. Do you wear contact lenses, eyeglasses or dental appliance? _____
___	___	14. Do you have any missing or non-functioning organs such as testes, eye, kidney, etc.? _____
___	___	15. Have you begun menses yet? _____
___	___	16. Do you have any other significant health problems? _____
___	___	17. Hepatitis B Immunization Series? _____
___	___	18. Date Of Last Tetanus Immunization _____

Parent/Guardian Signature: _____



PART III -- PHYSICAL EXAMINATION

(To be completed and signed by examining physician)

NAME: _____

HEIGHT _____ WEIGHT _____ SEX _____ AGE _____

*Tanner Stage or Maturation Index _____ BP _____

*Percent Body Fat _____ *Pulse (rest) _____

(Exercise) _____

(Recovery) _____

*Vision: Corrected (L) _____ (R) _____ Both _____

Uncorrected (L) _____ (R) _____ Both _____

*Audiogram: _____ Cervical spine/neck _____

Back _____

Eyes _____ Shoulders _____

Ears _____ Arm/elbow/wrist/hand _____

Nose _____ Knees/hips _____

Throat _____ Ankles/feet _____

Teeth _____

Skin _____

Lab:

Lymphatic _____

*Urine

Lungs _____

*Hemoglobin or HCT _____

Heart _____ and/or Fe Stores _____

Abdomen _____

Genitalia/hernia _____

***WHEN MEDICALLY INDICATED**

Peripheral pulses _____

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

_____ Full Participation _____ Limited Participation
_____ No Participation _____ Needs Additional Evaluation

If not full participation give reasons & recommendations: _____

Any recommendations or concerns on such items as:

- a. Weight loss or gain or restrictions of weight loss: _____
- b. Slow and careful monitoring of conditioning because of being overweight or show an abnormal exercise testing: _____
- c. Other _____

Physician Signature _____, M.D.* Date _____

*Doctor of Medicine, Doctor of Osteopathy or Licensed Nurse Practitioner

Physician Name (print) _____

Address _____

City/State/Zip Code _____

Telephone Number _____



PART IV -- ACKNOWLEDGEMENT OF RISK

(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: basketball, cheerleading, cross country, field hockey, golf, lacrosse, soccer, softball, baseball, swimming/diving, tennis, volleyball, dance, other (identify sports).

I have reviewed and understand 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 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.

Parent/Guardian Signature

Date