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 - 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.

<table>
<thead>
<tr>
<th>GENERAL MEDICAL HISTORY</th>
<th>Yes</th>
<th>No</th>
<th>MEDICAL QUESTIONS (cont)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has a doctor ever denied or restricted your participation in sports for any reason?</td>
<td>☐</td>
<td>☐</td>
<td>29. Do you have groin pain or a painful bulge or hernia in the groin area?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. Do you currently have an ongoing medical condition? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections ☐ Other:</td>
<td>☐</td>
<td>☐</td>
<td>30. Have you had mononucleosis (mono) within the last month?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. Have you ever spent the night in the hospital?</td>
<td>☐</td>
<td>☐</td>
<td>31. Do you have any rashes, pressure sores, or other skin problems?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. Have you ever had surgery?</td>
<td>☐</td>
<td>☐</td>
<td>32. Have you ever had a herpes or MRSA skin infection?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. Have you ever passed out or nearly passed out during or after exercise?</td>
<td>☐</td>
<td>☐</td>
<td>33. Are you currently taking any medication on daily basis?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. Have you ever had discomfort, pain, or pressure in your chest during exercise?</td>
<td>☐</td>
<td>☐</td>
<td>34. Have you ever had a head injury or concussion? If so, date of last injury:</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7. Does your heart rate or skip beats during exercise?</td>
<td>☐</td>
<td>☐</td>
<td>35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>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:</td>
<td>☐</td>
<td>☐</td>
<td>36. Have you been unable to move your arms or legs after being hit or falling?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9. Has a doctor ever ordered a test for your heart? (For ex: ECG/EKG, echocardiogram)</td>
<td>☐</td>
<td>☐</td>
<td>37. When exercising in heat, do you have severe muscle cramps or become ill?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10. Do you get lightheaded or feel more short of breath than expected during exercise?</td>
<td>☐</td>
<td>☐</td>
<td>38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>11. Have you ever had an unexplained seizure?</td>
<td>☐</td>
<td>☐</td>
<td>39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>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)?</td>
<td>☐</td>
<td>☐</td>
<td>40. Have you had any other blood disorders?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>13. Does anyone in your family have a heart problem?</td>
<td>☐</td>
<td>☐</td>
<td>41. Have you had any problems with your eyes or vision?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>14. Does anyone in your family have a pacemaker or implanted defibrillator?</td>
<td>☐</td>
<td>☐</td>
<td>42. Do you wear glasses or contact lenses?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>15. Does anyone in your family have Marfan syndrome, cardiomyopathy, or Long Q-T?</td>
<td>☐</td>
<td>☐</td>
<td>43. Do you wear protective eyewear, such as goggles or a face shield?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?</td>
<td>☐</td>
<td>☐</td>
<td>44. Do you worry about your weight?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>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?</td>
<td>☐</td>
<td>☐</td>
<td>45. Are you trying to or has any professional recommended that you try to gain or lose weight?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>18. Have you had any broken or fractured bones or dislocated joints?</td>
<td>☐</td>
<td>☐</td>
<td>46. Do you limit or carefully control what you eat?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>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?</td>
<td>☐</td>
<td>☐</td>
<td>47. Do you have any concerns that you would like to discuss with a doctor?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>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?</td>
<td>☐</td>
<td>☐</td>
<td>48. What is the date of your last Tdap orTd(tetanus) immunization? (circle type) Date:</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>21. Have you ever had a stress fracture of a bone?</td>
<td>☐</td>
<td>☐</td>
<td>49. Do you have an allergy to medicine, food or stinging insects?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>22. Do you regularly use a brace or assistive device?</td>
<td>☐</td>
<td>☐</td>
<td>FEMALES ONLY 50. Have you ever had a menstrual period?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>23. Do you currently have a bone, muscle, or joint injury that bothers you?</td>
<td>☐</td>
<td>☐</td>
<td>51. Age when you had your first menstrual period:</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>24. Do any of your joints become painful, swollen, feel warm, or look red?</td>
<td>☐</td>
<td>☐</td>
<td>52. How many periods have you had in the last 12 months?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>25. Do you have a history of juvenile arthritis or connective tissue disease?</td>
<td>☐</td>
<td>☐</td>
<td>✓ List medications and nutritional supplements you are currently taking here:</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

EXPLAIN “YES” ANSWERS BELOW:

#_»

#_»

#_»

#_»

#_»

Parent/Guardian Signature: __________________________ Date:_________ Athlete’s Signature: __________________________
### PART III – PHYSICAL EXAMINATION

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

<table>
<thead>
<tr>
<th>NAME ____________________________________</th>
<th>Date of Birth</th>
<th>School ________________________________</th>
</tr>
</thead>
</table>

#### Date of EXAMINATION:

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BP /</th>
<th>Resting Pulse</th>
<th>Vision R 20/</th>
<th>L 20/</th>
<th>Corrected</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### MEDICAL

**NORMAL**

<table>
<thead>
<tr>
<th>Appearance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes/ears/nose/throat</td>
</tr>
<tr>
<td>Lymph nodes</td>
</tr>
<tr>
<td>Heart</td>
</tr>
<tr>
<td>Pulses</td>
</tr>
<tr>
<td>Lungs</td>
</tr>
<tr>
<td>Abdomen</td>
</tr>
<tr>
<td>Genitourinary (males only)</td>
</tr>
<tr>
<td>Skin</td>
</tr>
<tr>
<td>Neurologic</td>
</tr>
</tbody>
</table>

**ABNORMAL FINDINGS**

### MUSCULOSKELETAL

**NORMAL**

<table>
<thead>
<tr>
<th>Neck</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back</td>
</tr>
<tr>
<td>Shoulder/arm</td>
</tr>
<tr>
<td>Elbow/forearm</td>
</tr>
<tr>
<td>Wrist/hand/fingers</td>
</tr>
<tr>
<td>Hip/thigh</td>
</tr>
<tr>
<td>Knee</td>
</tr>
<tr>
<td>Leg/ankle</td>
</tr>
<tr>
<td>Foot/toes</td>
</tr>
<tr>
<td>Functional</td>
</tr>
</tbody>
</table>

### 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 WITHOUT RESTRICTIONS**
- **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** __________________

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

Rule 28-9-1 (3) Physical Examination Rule/Transfer Student (10-90) – When an out-of-state student who has received a current physical examination elsewhere transfers to Virginia and attaches proof of that physical examination to the League’s form #2, the student is in compliance with physical examination requirements.
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 in case of an emergency
______________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________

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 emergency) ________________________________________________
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
HIGHLAND SCHOOL
Concussion Education Acknowledgement

I have read and understand the information provided in the Highland Concussion Education Brochure and will follow the guidelines given in regards to recognizing the signs, symptoms, and management of a concussion if one should occur with my child.

Signatures:

________________________________________  __________________________  __________
Student Athlete Name (print)   Student Athlete Signature  Date

________________________________________  __________________________  __________
Parent or Legal Guardian Name (print)   Parent or Legal Guardian Signature  Date

If you have any questions regarding Concussions, or if you suspect your child has a concussion, please call Highland's Athletic Trainer, Carla Richardson, MSEd, ATC, VATL, at 540-878-2765 (office) or email to: crichardson@highlandschool.org.
WHAT IS A CONCUSSION?

There is no standard definition of concussion that is agreed upon in the medical profession community. This is part of what makes the injury so difficult to diagnose and treat.

For our purposes here, a concussion is defined as a type of traumatic brain injury (TBI) caused by a bump, blow, or jolt to the head, face, or neck and results in altered functioning of the brain that can manifest in a variety of ways. It is important to know that loss of consciousness does not need to occur for the injury to be classified as a concussion. All head injuries, concussion or no concussion, need to be taken seriously.

HOW PREVALENT ARE CONCUSSIONS?

The Center for Disease Control and Prevention (CDC) states that children aged 0 to 4 years, older adolescents aged 15 to 19 years, and adults aged 65 years and older are most likely to sustain a TBI.

Almost half a million (473,947) emergency department visits for Traumatic Brain Injury (TBI; concussion) are made annually by children aged 0 to 14 years of age. An estimated 1.7 million people sustain a TBI annually.
WHAT ARE THE SYMPTOMS OF A CONCUSSION?

Categories of Concussion Symptoms**

THINKING/REMEMBERING
- Difficulty thinking clearly/confusion
- Feeling “foggy” or mentally slowed down
- Difficulty concentrating
- Difficulty remembering information – before or after the head injury

PHYSICAL
- Headache/pressure in the head
- Fuzzy or blurry vision
- Nausea or vomiting
- Dizziness
- Sensitivity to noise or light
- Balance Problems
- Slowed reaction time
- Fatigue/lack of energy

EMOTIONAL/MOOD
- Irritability
- Sadness
- More emotional
- Nervousness/anxiety
- Not acting like one’s self

SLEEP
- Sleeping more or less than usual
- Trouble falling asleep

**Some symptoms may appear right away, while others may not be noticed for hours, days, or even months following the injury.

WHAT SHOULD I DO IF I SUSPECT MY CHILD HAS SUSTAINED A CONCUSSION?

Contact Highland’s Athletic Trainer, Carla Richardson, or your Physician!
Concussions are a specific injury that should be treated by specially trained health care providers - sports medicine physicians, athletic trainers, and neurologists, for example.

NOT ALL PHYSICIANS ARE TRAINED IN THE MOST CURRENT CONCUSSION MANAGEMENT PRACTICES. For example, emergency department physicians are not to be used for long term concussion management. The emergency department is a much needed part of treatment for the immediate care and ruling out of more serious brain injuries (such as a subdural hematoma or skull fracture), but not for return to play decisions.
HOW DO I KNOW WHEN IT IS SAFE FOR MY CHILD TO RETURN TO PLAY?

A team of licensed health care providers will work together to determine when it is safe to return to play. Management will include ImPACT neurocognitive testing, a gradual monitored exertional test, and daily symptom monitoring. Before an athlete can return to full participation, he/she must be cleared by a physician that is trained in concussion management.

WHAT ARE THE LONG TERM EFFECTS OF A CONCUSSION?

Long-term effects of concussions, while still being studied, are not fully known. It is generally accepted that multiple concussions may lead to long-term memory loss, psychiatric disorders and other neurologic disorders. More importantly, sustaining additional head trauma, while not fully recovered from a concussion, can be life threatening. This is commonly referred to as Second-Impact Syndrome.

ImPACT Neurocognitive Testing

ImPACT is a computerized neurocognitive test used to evaluate certain functions of the brain both when the athlete is healthy and following a head injury. More information can be obtained at www.impacttest.com.

PRE-SEASON: ImPACT baseline testing will be administered through Highland's Athletic Department to all contact sport athletes as soon as possible at the beginning of the sports season.

HEAD INJURIES: Following any respective head injury, a post-injury test will be administered once the athlete is completely asymptomatic or at the request of a physician. The results of the post-injury test are used to help determine when an athlete is safe to return to play.

For more information regarding ImPACT, please visit the ImPACT website above or see Highland's Athletic Trainer:

Carla Richardson, MSEd, ATC, VATL - HIGHLAND ATHLETIC TRAINER
540-878-2765 (office) • 540-347-0300 (fax)
crichardson@highlandschool.org
CAN THE RISK OF CONCUSSION BE REDUCED?

The risk of concussion is inherent to sport, and that risk varies by the type of sport. Taking steps to prevent concussion can potentially reduce their prevalence and severity.

- Know the signs and symptoms of a concussion and respond quickly and appropriately when you are concerned about a head injury.
- Teach and practice safe, proper technique when playing in sports.
- Encourage sportsmanship and insist that safety rules be followed, especially properly wearing protective equipment.
- Insist that your child allow for their concussion to heal before returning to play. When needed, seek appropriate medical treatment and work with your sports medicine team to facilitate the best outcomes for your child.

RESOURCES FOR THIS EDUCATIONAL HANDOUT:


ALL HIGHLAND PARENTS: The enclosed CONCUSSION EDUCATION ACKNOWLEDGEMENT page MUST be signed by all Highland athletes in contact sports and their parents PRIOR TO the start of each relevant sports season (fall, winter, spring). Highland athletes may NOT try out for contact sports without this form signed and turned in to Carla Richardson, Highland Athletic Trainer.