

**ATHLETIC PARTICIPATION/PARENTAL CONSENT/PHYSICAL EXAMINATION FORM – 2020-21 SCHOOL YEAR**

To be eligible for participation, this form must be completed AFTER May 1, 2020  
**You must return this form to the office before participation**

**PART I-ATHLETIC PARTICIPATION**  
(To be filled in and signed by the student)

Student's Name \_\_\_\_\_  
(last) (first) (middle initial)

Home Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Emergency Phone Number: \_\_\_\_\_

**Statement of Commitment**

As a member of St. Michael's Episcopal School's athletic team, I fully understand that I am expected to attend all practices and games. Exceptions would be conflict with another school activity, a family emergency, or illness. Further, I understand that if I miss practice or a game for other reasons, I may lose the privilege of representing St. Michael's on that team.

\_\_\_\_\_  
Student Signature Date

**The St. Michael's Athlete Should:**

1. Not lose his/her temper or use profanity when in practice or competition.
2. Be courteous to visiting teams and officials.
3. Play hard and to the limit of his/her ability, regardless of discouragement. The true athlete does not give up but continues to strive to meet team and individual goals.
4. Be gracious in defeat and modest in victory. A true sportsman does not offer excuse for failures.
5. Maintain a high degree of physical fitness by observing team and training rules conscientiously.
6. Respect the facilities of host schools and uphold the trust placed in you as a guest.
7. In the classroom strive for perfect attendance, take responsibility for completing academic assignments on time, and encourage others to improve their academic work.
8. Demonstrate loyalty to the school by performing academically to the best of your ability and be participating in or supporting other school activities.
9. Should not engage in any activity that includes alcohol, tobacco, or any other controlled substance.

I have read and understand the above expectations of a St. Michael's athlete and will do my best to uphold each one who a member of a St. Michael's team.

\_\_\_\_\_  
Student Signature Date

**PART II- MEDICAL HISTORY**

This form should be completed by parent and athlete prior to the time of the physical examination and should be taken with physical examination form for review by the physician during the examination.

YES      NO

- |       |       |   |
|-------|-------|---|
| _____ | _____ | 1. Have you ever had any of the following? Please explain any YES answers                                 |
| _____ | _____ | 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 _____  |
| _____ | _____ | B. Do you have prescription for use of:   |
| _____ | _____ | Adrenalin _____   |
| _____ | _____ | Inhaler _____   |
| _____ | _____ | Other allergy medicine _____  |
| _____ | _____ | C. Do you have asthma? _____  |
|       |       |   |
| _____ | _____ | 7. Do you take any medicine regularly? _____  |
|       |       |   |
| _____ | _____ | 8. Have you had any illnesses lasting a week or more such as mononucleosis, etc? _____                    |
|       |       |   |
| _____ | _____ | 9. Have you had any blood disorders, including sickle-cell trait, anemia, etc.? _____                     |
|       |       |   |
| _____ | _____ | 10. Has any family member had a heart attack, heart problems or sudden death before the age of 50? _____? |
|       |       |   |
| _____ | _____ | 11. Do you wear contact lenses, eyeglasses or dental appliance? _____                                     |
|       |       |   |
| _____ | _____ | 12. Do you have any missing or non-functioning organs such as testes, eye, kidney, etc.? _____            |
|       |       |   |
| _____ | _____ | 13. Menstrual History:  |
| _____ | _____ | Have you begun menses yet? _____  |
|       |       |   |
| _____ | _____ | 14. Do you have any other significant health problems? _____  |
|       |       |   |
| _____ | _____ | 14. <b>DATE OF LAST TETANUS or Tdap IMMUNIZATION? _____</b>   |
| _____ | _____ | <b>MUST HAVE Tdap IN ORDER TO ENTER 6<sup>TH</sup> GRADE</b>  |

**PART III – PHYSICAL EXAMINATION**

(To be completed and signed by examining physician)

NAME \_\_\_\_\_ SCHOOL \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ SEX \_\_\_\_\_ AGE \_\_\_\_\_ GRADE \_\_\_\_\_

\*Tanner Stage or Maturation Index

\*Vision: corrected (L) \_\_\_\_\_ (R) \_\_\_\_\_

Blood Pressure \_\_\_\_\_

Eyes \_\_\_\_\_

Cervical spine/neck \_\_\_\_\_

Ears \_\_\_\_\_

Back \_\_\_\_\_

Nose \_\_\_\_\_

Shoulders \_\_\_\_\_

Teeth \_\_\_\_\_

Arm/elbow/wrist/hand \_\_\_\_\_

Skin \_\_\_\_\_

Knees/hips \_\_\_\_\_

Lungs \_\_\_\_\_

Lab:

Lymphatics \_\_\_\_\_

\*Urine \_\_\_\_\_

Heart \_\_\_\_\_

\*Hemoglobin or HCT \_\_\_\_\_

Abdomen \_\_\_\_\_

and/or Fe Stores \_\_\_\_\_

Genitalia/hernia \_\_\_\_\_

\*WHEN MEDICALLY INDICATED

Peripheral pulses \_\_\_\_\_

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

\_\_\_ Full participation    \_\_\_ Limited participation    \_\_\_ No Participation    \_\_\_ Needs Additional Evaluation

If not full participation, give reasons and 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 showing an abnormal exercise testing: \_\_\_\_\_
- c. Other \_\_\_\_\_

Physician Name (print) \_\_\_\_\_ Signature \_\_\_\_\_ M.D.\* DATE \_\_\_\_\_

Address \_\_\_\_\_ Telephone Number \_\_\_\_\_

City/Zip Code \_\_\_\_\_

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

**PART IV – ACKNOWLEDGEMENT OF RISK AND INSURANCE STATEMENT**

(To be completed and signed by parent/guardian)

I give permission for \_\_\_\_\_ to participate in any of the following sports that are not crossed out: baseball, basketball, field hockey, soccer, softball, track, 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. 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 is insured by our family policy with:

\_\_\_\_\_  
Name of Company

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
Name of Insured

I acknowledge and accept the risk inherent in the sport and with this knowledge in mind, grant permission for my child to participate in the sport.

I also give my consent and approval for my child to receive a physical examination, as required in Part III, Physical Examination, of this form, by \_\_\_\_\_ M.D., O.D. or L.NP

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

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

**PART V - EMERGENCY PERMISSION FORM**

**Student's Name** \_\_\_\_\_ **Grade** \_\_\_\_\_ **Age** \_\_\_\_\_

Emergency Authorization: In the event I cannot be reached in an emergency, I hereby give permission to physicians selected by coaches and staff of St. Michael's Episcopal 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 \_\_\_\_\_ Evening phone number \_\_\_\_\_

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

Relationship to student \_\_\_\_\_