Town of Marion

P.O. Box 1005 Marion, VA 24354

Athletic Participation/Parental Consent/Physical Examination Form

Part I- Athletic Participation

(To be filled in and signed by the parent)

Male _____

Female_____

PRINT CLEARLY

Name _____

Home Address_____

City/Zip Code_____

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 practicioner. Explain "Yes" answers below with number of question. Circle questions you don't know the answer to.

GENERAL MEDICAL HISTORY	Yes	No	MEDICAL QUESTIONS (cont.)	Yes	No
1. Has a doctor ever denied or restrictred your participation in sports for any reason?			29. Do you ave groin pain or a painful bulge or hernia in the groin area?		
2. Do you currently have an ongoing medical conditon? If so, Please Identify: _Asthma _Anemia _Diabetes _Infections _Other			30. Have you had mononucleosis (mono) within the last month?		
3. Have you ever spent the night in the hospital?			31. Do youhave any rashes, pressure sore, or other skin problems?		
4. Have you ever had surgery?			32. Have you ever had a herpes or MRSA skin infection?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**	33. Are you currently taking any medication on daily basis?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			34. Have you ever had a head injury or concussion? If so, date of last injury:		
6. Have you ever had discomfort, pain, or pressure in your chest during exercise?			35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
7.Does you heart race or skip beats during exercise?			36. Do you have headaches with exercise?		
8. Has a doctor ever told you that you have (check all that apply): _High Blood Pressure _High cholesterol _Kawasaki Disease _A heart murmur _A Heart infection _other			37. Have you ever been unable to move your arms or legs after being hit or falling?		
9. Has a doctor ever ordered a test or your heart? (For ex: ECG?EKG, echocardiogram)			38. When exercising in heat, do you have severe muscle cramps or become ill?		
10. :Do you get lightheaded or feel more shot of breath than expected during exercise?			39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
11.Have you ever had an unexplained seizure?			40. Have you had any other blood disorders?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**	41. Have you had any problems with your eyes or vision?		
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 syndrome)?			42. Do you wear glasses or contact lenses?		
13.Does anyone in your familyhave a heart problem?			43. Do you wear protective eyewear, such as goggles or a face shield?		
14. Does anyone in your family have a pacemaker or implanted defibrillator?			44. Do you worry about your weight?		
15. Does anyone in your family have Marfan syndome, cardiomyopathy, or Long Q-T?			45. Are you trying to or has any professional recommended that you try to gain or lose weight?		

16. Has anyone in your family had unexplained fainting, unexplained seziures, or near drowning?			46. Do you limit or carefull control what you eat?		
BONE AND JOINT QUESTIONS	**Yes**	**No**	47. Do you have any concerns that you would like to discuss with a doctor?		
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tenonitis that caused you to miss practice or game?			48. What is the date of your last Tdap or Td (tetanus) immunization? (Circle type) Date:_____		
18. Have you had any broken or fractured bones or dislocated joints?			49. Do you have an allergy to medicine, food or stinging insects?		
19. Have you had a bone or joint that required x-rays, MRI, CT, surgery, injections, rehabilitations, physical therapy, a brace, a cast, or cutches?			**FEMALES ONLY** 50. Have you ever had a menstrual period?		
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?			51. Age when you had your first menstrual period?		
21. Have you ever had a stress fracture of a bone?			52. How many periods have you had in the last 12 months?		
22. Do you regurarly use a brace or assistive device?			Explain "Yes" Answers Below:		
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					
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?			*List medications and nutritional supplements you are currently taking here:		
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?					

Parent/Guardian Signature:_____ Date:_____

PART III - PHYSICAL EXAMINATION

Physical examination form is required once each 12 calendar months.

Name_____ Date of Birth_____ School_____

Height	Weight	Male____ Female____	
BP /	Resting Pulse	Vision R 20/ L20/	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 Town 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 THE FOLLOWING NOTATION:_____

____ Cleared AFTER documented further evaluation or treatment for:_____

____ NOT CLEARED FOR PARTICIPATION Reason _____

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

Physicians Signature:_____(MD,DO,LNP,PA). Date:_____

Examiner's Name and degree (print):_____Phone #_____

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 (identify sports). _____

By this signature, I hereby consent to allow the physician(s) and other health care provider(s) selected by myself to perform a pre-participation examination on my child and to provide treatment for any injury or condition resulting from participating in athletics 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 Recreation Department personnel as deemed necessary.

PART V- EMERGENCY PERMISSION FORM

(To be completed and signed by parent/guardian)

CHILD'S NAME _____ GRADE ____ AGE____DOB_____

Please list any allergies to medications, etc._____

_____

_____

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

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

Does child wear contact lenses?_____ Date of last Tdap or Td (tetanus) shot_____

EMERGENCY AUTHOIZATION: In the event I cannot be reached in an emergency, I hereby give permission to physicians selected by the staff of Town of Marion Recreation Department to hospitalize or secure proper treatment 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 of guardian _____ Date_____

Relationship to student _____

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.