## Washington Montessori Public Charter School

Athletic Participation Form

Name _____ Date of Birth _____

Eligibility: In order to be eligible for any athletic activity, the athlete:

- Must maintain a minimum of a grade of 70 in ALL courses.
- Must complete and Athletic Participation Form and turn in to the school. (A physical is valid for 365 days from the date of the examination).
- Must, if you miss five (5) or more days of practice due to illness or injury, receive a medical release from a licensed physician before practicing or playing.
- Must meet promotion requirements for all previous school year in order to be eligible for the fall semester.
- Must not practice OR play if ineligible.
- Must practice a total of six (6) days before playing in a game.
- Must be present 100% of the student day on the day of an athletic contest.
- All academic and attendance requirements must be met the first semester (fall) in order for this students to be eligible for athletic participation the second semester (spring).

Transportation: Parents provide transportation to and from athletic events. Athletic events include practices and/or games of the sports offered by WMPCS. By signing this form, I am giving my child permission to participate in all on-campus (home) and off-campus (away) games. Permission is granted to WMPCS to arrange transportation for my student if it is available. I understand that transportation to games is not guaranteed/athletic events are not guaranteed. Transportation is up to the discretion of administration, athletic coordinator, or coach.
Sportsmanship: It is recognized that the public school interscholastic athletic events should be conducted in such a manner that good sportsmanship prevails at all times. Every effort should be made to promote a climate of wholesome competition. Unsportsmanlike acts will not be tolerated. Players are under the coach's guidance from the time they arrive at the athletic facility until they leave. Noncompliance with these exceptions may result in consequential action being taken at the school, including but not limited to removal from the team or suspension.

Secondary Sports: Student athletes who participate in multiple sports at the same time are required to attend at least one practice per week to be eligible to participate in games.

Student Athlete Pledge: As a student athlete, I am a role model. I understand that spirit of fair play while playing hard. I will refrain from engaging in all types of disrespectful behavior, including inappropriate language, taunting, trash talking, and unnecessary physical contact. I know the behavior exceptions of my school. And hereby accept the responsibility and privilege of representing this school and community as a student athlete. I understand that once the sports season begins, it is my obligation to fulfill my commitment as a member of the team. This means I will attend all practices and games unless there is an urgent matter. In the case that I am not able to attend a game or practice, I understand that I am to notify the athletic coordinator as soon as possible. I also understand that sports are an extracurricular activity I may only be involved in if I am able to maintain good grades in all subjects.

Parents Pledge: As a parent, I acknowledge that I am a role model. I will remember that school athletics is an extension of the classroom, offering learning experiences for the students. I must show respect for all players, coaches, spectators, and support groups. I will participate in sheers that support, encourage, and uplift the teams involved. I understand the spirit of fair play and the good sportsmanship expected by our school. I hereby accept my responsibility to be a model of good sportsmanship that comes with being the parent of a student athlete.

Sports Medicine: Permission is granted to the WMPCS coaches to provide any necessary minor or emergency treatment(s) to the student athlete prior to his/her admission to any medical facility. Permission is hereby granted to the attending physician to proceed with any medical or surgical treatment for the above-named student athlete. I understand that every effort will be made by the attending physician to contact me prior to treatment. Permission is granted to the assigned WMPCS coaches, to examine records concerning examination or treatment received by the student athlete. These records may be examined for the express purpose of evaluating medical or physical fitness for participation in, or continued participation in, any athletic program in WMPCS. I agree to furnish the WMPCS coaches with any reports or copies of medical records that are requested. I understand that these medical records will be kept confidential.

Parent/Guardian Permission to Participate: The student's parent(s) or guardian(s) grant permission for their student to participate in interscholastic athletics in the following sports.

( ) Soccer ( ) Volleyball ( ) Cross Country ( ) Basketball

Parental Permission: I have read and reviewed the general requirements for athletic eligibility, and have discussed these requirements with my student athlete. I understand that additional questions or specific circumstances should be directed to my student's coach, athletic director, or WMPCS Head of School. I certify as a parent/guardian that the home address on this form is my sole bona fide residence. All other information on this form is accurate and current. Providing dates information on this form may cause the student athlete to lose athletic eligibility. I have read, reviewed, completed (where necessary), and agree to comply with the requirements set forth in this document. This document is valid only for the school year in which it is signed.

Parent/Guardian Signature Date

Student Athlete: I certify that the above information is correct, that I have read and reviewed all of the above information with my parent(s)/guardian(s), and I agree to comply these standards as well as those established by the WMPCS Head of School, athletic coordinator, and coach.

Student Athlete Signature Date

# Gfeller-Waller NCHSAA Student-Athlete & Parent/Legal Custodian Concussion Information Sheet

**What is a concussion?** A concussion is an injury to the brain caused by a direct or indirect blow to the head. It results in your brain not working as it should. It may or may not cause you to black out or pass out. It can happen to you from a fall, a hit to the head, or a hit to the body that causes your head and your brain to move quickly back and forth.

**How do I know if I have a concussion?** There are many signs and symptoms that you may have following a concussion. A concussion can affect your thinking, the way your body feels, your mood, or your sleep. Here is what to look for:

| Thinking/Remembering | Physical | Emotional/Mood | Sleep |
|---|---|---|---|
| Difficulty thinking clearly | Headache | Irritability-things bother you more easily | Sleeping more than usual |
| Taking longer to figure things out | Fuzzy or blurry vision | Sadness | Sleeping less than usual |
| Difficulty concentrating | Feeling sick to your stomach/queasy | Being more moody | Trouble falling asleep |
| Difficulty remembering new information | Vomiting/throwing up | Feeling nervous or worried | Feeling tired |
| | Dizziness | Crying more | |
| | Balance problems | | |
| | Sensitivity to noise or light | | |

*Table is adapted from the Centers for Disease Control and Prevention (http://www.cdc.gov/concussion/)*

**What should I do if I think I have a concussion?** If you are having any of the signs or symptoms listed above, you should tell your parents, coach, athletic trainer or school nurse so they can get you the help you need. If a parent notices these symptoms, they should inform the school nurse or athletic trainer.

**When should I be particularly concerned?** If you have a headache that gets worse over time, you are unable to control your body, you throw up repeatedly or feel more and more sick to your stomach, or your words are coming out funny/slurred, you should let an adult like your parent or coach or teacher know right away, so they can get you the help you need before things get any worse.

**What are some of the problems that may affect me after a concussion?** You may have trouble in some of your classes at school or even with activities at home. If you continue to play or return to play too early with a concussion, you may have long term trouble remembering things or paying attention, headaches may last a long time, or personality changes can occur Once you have a concussion, you are more likely to have another concussion.

**How do I know when it's ok to return to physical activity and my sport after a concussion?** After telling your coach, your parents, and any medical personnel around that you think you have a concussion, you will probably be seen by a doctor trained in helping people with concussions. Your school and your parents can help you decide who is best to treat you and help to make the decision on when you should return to activity/play or practice. Your school will have a policy in place for how to treat concussions. You should not return to play or practice on the same day as your suspected concussion.

***You should not have any symptoms at rest or during/after activity when you return to play, as this is a sign your brain has not recovered from the injury.***

*This information is provided to you by the UNC Matthew Gfeller Sport-Related TBI Research Center, North Carolina Medical Society, North Carolina Athletic Trainers' Association, Brain Injury Association of North Carolina, North Carolina Neuropsychological Society, and North Carolina High School Athletic Association.*

# Gfeller-Waller NCHSAA Student-Athlete & Parent/Legal Custodian Concussion Statement Form

Instructions: The student athlete and his/her parent or legal custodian, must initial beside each statement acknowledging that they have read and understand the corresponding statement. The student-athlete should initial in the left column and the parent or legal custodian should initial in the right column. Some statements are applicable only to the student-athlete and should only be initialed by the student-athlete. This form must be completed for each student-athlete, even if there are multiple student-athletes in the household.

Student-Athlete Name: (please print)_____

Parent/Legal Custodian Name(s): (please print)_____

| Student-Athlete Initials | | Parent/Legal Custodian(s) Initials |
|---|---|---|
| | A concussion is a brain injury, which should be reported to my parent(s) or legal custodian(s), my or my child's coach(es), or a medical professional if one is available. | |
| | A concussion cannot be "seen." Some signs and symptoms might be present immediately; however, other symptoms can appear hours or days after an injury. | |
| | I will tell my parents, my coach and/or a medical professional about my injuries and illnesses. | Not Applicable |
| | If I think a teammate has a concussion, I should tell my coach(es), parent(s)/ legal custodian(s) or medical professional about the concussion. | Not Applicable |
| | I, or my child, will not return to play in a game or practice if a hit to my, or my child's, head or body causes any concussion-related symptoms. | |
| | I, or my child, will need written permission from a medical professional trained in concussion management to return to play or practice after a concussion. | |
| | Based on the latest data, most concussions take days or weeks to get better. A concussion may not go away, right away. I realize that resolution from a concussion is a process that may require more than one medical visit. | |
| | I realize that ER/Urgent Care physicians will not provide clearance to return to play or practice, if seen immediately or shortly after the injury. | |
| | After a concussion, the brain needs time to heal. I understand that I or my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before concussion symptoms go away. | |
| | Sometimes, repeat concussions can cause serious and long-lasting problems. | |
| | I have read the concussion symptoms listed on the Student-Athlete/ Parent Legal Custodian Concussion Information Sheet. | |
| | I have asked an adult and/or medical professional to explain any information contained in the Student-Athlete & Parent Concussion Statement Form or Information Sheet that I do not understand. | |

**By signing below, we agree that we have read and understand the information contained in the Student-Athlete & Parent/Legal Custodian Concussion Statement Form, and have initialed appropriately beside each statement.**

_____ _____

Signature of Student-Athlete Date

_____ _____

Signature of Parent/Legal Custodian Date

# 2022-2023 NCHSAA ELIGIBILITY, CONSENT TO PARTICIPATE, AND RELEASE FORM

**THIS DOCUMENT MUST BE SIGNED BY THE STUDENT-ATHLETE OF AN NCHSAA MEMBER SCHOOL AND BY THE STUDENT-ATHLETE'S PARENT OR LEGAL CUSTODIAN BEFORE PARTICIPATION. STUDENT-ATHLETES MAY NOT PARTICIPATE WITHOUT THE SIGNATURE OF THE STUDENT-ATHLETE AND PARENT(S)/LEGAL CUSTODIAN.**

I (the student-athlete and parent(s)/legal custodian) acknowledge that I have read and understand the eligibility rules applicable to participation in sports through the North Carolina High School Athletic Association (NCHSAA). I understand that a copy of the NCHSAA Handbook is on file with the member school's principal and/or Athletic Director, and that I may review it, in its entirety if I so choose. I know my school is a member of the NCHSAA and must adhere to all regulations that govern interscholastic athletic programs, including, but not limited to, Federal and State laws, local regulations, and the rules and regulations of the NCHSAA. I agree to follow the rules of my school and the NCHSAA and to abide by their decisions. I acknowledge and understand that participation in interscholastic athletics is a privilege, not a right. I understand that classroom performance, dropping a class, or taking coursework through other educational options could affect eligibility and compliance with NCHSAA academic standards.

## STUDENT CODE OF RESPONSIBILITY

As a student-athlete, I **understand and accept** the following responsibilities:

I will **respect the rights and beliefs** of others and will treat others with courtesy and consideration. I will be **fully responsible** for my own actions and the consequences of my actions.
I will **respect the property** of others.
I will **respect and obey the rules** of my school and the laws of my community, state, and country.
I will **show respect to those who are responsible for enforcing the rules** of my school and the laws of my community, state, and country.
I **understand that a student whose character or conduct violates** the school's Athletic Code or School Code of Responsibility could be deemed ineligible for a period of time as determined by the principal or school system Administration.

**PARENTS, LEGAL CUSTODIANS, OR STUDENT-ATHLETES WHO DO NOT WISH TO ACCEPT THE RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM.**

I (the student-athlete and parent(s)/legal custodian) recognize that participation in interscholastic athletics involves some inherent risks for potentially severe injuries including, but n limited to, serious neck, head and spinal injuries, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal systen serious injury or impairment to other aspects of the body, or effects to the general health and well-being of the child, and in rare cases, death. Although serious injuries are n common in supervised school athletic programs, it is impossible to eliminate all risk. The student-athlete and parent(s)/legal custodian have a responsibility to help reduce th risk. I understand that student-athletes must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspe their own equipment daily.

I (the student-athlete and parent(s)/legal custodian) authorize medical treatment should the need arise for such treatment while the student-athlete is under the supervision of the member school. I **consent to medical treatment** for the student-athlete following an injury or illness suffered during practice and/or a contest. I understand that in the case of **injury or illness requiring treatment by medical personnel and transportation to a health care facility**, a reasonable attempt will be made to contact the parent/legal custodian if the student-athlete is a minor, but that, if necessary, the student-athlete will be treated and transported via ambulance to the nearest hospital. I further authorize the use o disclosure of the student-athlete's personally identifiable health information should treatment for illness or injury become necessary.

I (the student-athlete and parent(s)/legal custodian) **understand all concussions are potentially serious** and may result in complications including prolonged brain damage and death if not recognized and managed properly. Further, I understand that if the student-athlete is removed from a practice or competition due to a suspected concussion, he or she will be unable to return to participation unless and until clearance is given in compliance with applicable laws. I also acknowledge that I **have received, read, and signed** the Gfeller- Waller Concussion Information Sheet, **as well as viewed the CrashCourse concussion education video.**

I (the student-athlete and parent(s)/legal custodian) **consent to the NCHSAA's use of the student-athlete's name**, image, likeness, and athletic-related information in reports of contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics, and grant the NCHSAA the right to photograph and/or videotape the participant and further to use the student-athlete's face, likeness, voice, and appearance in connection with exhibitions, publicity, advertising, promotional, and commercial materials without reservation or limitation. The NCHSAA, however, is under no obligation to exercise said rights herein. I further consent to the disclosure, by the member school to the NCHSAA upon the NCHSAA's request, of all records relevant to the student-athlete's eligibility including, but not limited to, their records relating to enrollment, attendance, academic standing, age, discipline, finances, residence, and physical fitness. The student-athlete and parent/legal custodian, individually and on behal of the student-athlete, hereby irrevocably, and unconditionally release, acquit, and discharge, without limitation, the NCHSAA its officers, agents, attorneys, representatives, an employees (collectively, the "Releasees") from any and all losses, claims, demands, actions and causes of action, obligations, damages, and costs or expenses of any nature (including attorney's fees) that the student and/or legal custodian incur or sustain to person, property, or both, which arise out of, result from, occur during, or are otherwise connected with the student-athlete's participation in interscholastic athletics if due to the ordinary negligence of the Releasees.

**By signing this document, we acknowledge that we have read the above information and that we consent to participation by the herein named student-athlete. We understand that the authorizations and rights granted herein are voluntary and that we may revoke any or all of them at any time by submitting said revocation in writing to the student-athlete's member school. We understand that if we submit a revocation, the student-athlete will no longer be eligible for participation in interscholastic athletics; provided, however, that revoking authorization to use the student-athlete's name, image, likeness and athletic-related information will not affect eligibility.**

Student's Signature | Date of Birth | Grade in School | Date

Signature of Parent or Legal Custodian | Date

Instructions for Completing the NCHSAA Student-Athlete
Preparticipation Physical Evaluation (PPE)

In order to be medically eligible for participation in practice or in interscholastic athletic contests, a student must have a completed NCHSAA PPE and submit it to the school. The PPE is four (4) pages in length and includes the **History Form**, the **Physical Examination Form**, and the **Medical Eligibility Form**.

The PPE **History Form** (pages 1-2) is completed and signed by the parent or legal custodian on behalf of the student-athlete. The completed and signed PPE History Form must then be presented to the examining Licensed Medical Professional (LMP) (physician licensed to practice medicine (MD/DO), nurse practitioner or physician assistant) for review when they fill out the Physical Examination Form.

The completed PPE **Physical Examination Form** (page 3) is signed and dated by the LMP who performed the examination. The physical examination builds on information obtained in the medical history.

The PPE **Medical Eligibility Form** (page 4), which is also signed and dated by the LMP, indicates the student-athlete is either medically eligible or not medically eligible for sports participation.


# Student-Athlete COVID Questionnaire

Student-Athlete's Name: _____

Date of Birth: _____ Age: _____

| COVID RELATED QUESTIONS ABOUT THE STUDENT-ATHLETE | YES | NO | NA |
|---|---|---|---|
| 1. Since January 1, 2020 have you been told that you have had a positive test for COVID-19, **OR** have you been told by a medical professional, your school, or local health department that you have had to quarantine (stay home) due to concern that you had COVID-19 symptoms? | | | |
| 2. If the answer to 1 was "Yes", has the required *Return to Play Form: COVID-19 Infection Medical Clearance Releasing The Student-Athlete to Resume Full Participation in Athletics* been completed? | | | |
| 3. Have you been fully vaccinated against COVID? | | | |

## ■ PREPARTICIPATION PHYSICAL EVALUATION

# HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex: M/F _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4)

*Over the last 2 weeks, how often have you been bothered by any of the following problems? **(check box next to appropriate number)***

| | Not at all | Several days | Over half the days | Nearly every day |
|---|---|---|---|---|
| Feeling nervous, anxious, or on edge | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Not being able to stop or control worrying | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Little interest or pleasure in doing things | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Feeling down, depressed, or hopeless | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

| GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.) | Yes | No |
|---|---|---|
| 1. Do you have any concerns that you would like to discuss with your provider? | ☐ | ☐ |
| 2. Has a provider ever denied or restricted your participation in sports for any reason? | ☐ | ☐ |
| 3. Do you have any ongoing medical issues or recent illness? | ☐ | ☐ |
| **HEART HEALTH QUESTIONS ABOUT YOU** | **Yes** | **No** |
| 4. Have you ever passed out or nearly passed out during or after exercise? | ☐ | ☐ |
| 5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | ☐ | ☐ |
| 6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? | ☐ | ☐ |
| 7. Has a doctor ever told you that you have any heart problems? | ☐ | ☐ |
| 8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. | ☐ | ☐ |

| HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*) | Yes | No |
|---|---|---|
| 9. Do you get light-headed or feel shorter of breath than your friends during exercise? | ☐ | ☐ |
| 10. Have you ever had a seizure? | ☐ | ☐ |
| **HEART HEALTH QUESTIONS ABOUT YOUR FAMILY** | **Yes** | **No** |
| 11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)? | ☐ | ☐ |
| 12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? | ☐ | ☐ |
| 13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? | ☐ | ☐ |



Approved for Use Beginning March 2021

| BONE AND JOINT QUESTIONS | Yes | No |
|---|---|---|
| 14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game? | ☐ | ☐ |
| 15. Do you have a bone, muscle, ligament, or joint injury that bothers you? | ☐ | ☐ |
| **MEDICAL QUESTIONS** | **Yes** | **No** |
| 16. Do you cough, wheeze, or have difficulty breathing during or after exercise? | ☐ | ☐ |
| 17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? | ☐ | ☐ |
| 18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area? | ☐ | ☐ |
| 19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)? | ☐ | ☐ |
| 20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? | ☐ | ☐ |
| 21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? | ☐ | ☐ |
| 22. Have you ever become ill while exercising in the heat? | ☐ | ☐ |
| 23. Do you or does someone in your family have sickle cell trait or disease? | ☐ | ☐ |
| 24. Have you ever had or do you have any problems with your eyes or vision? | ☐ | ☐ |

| MEDICAL QUESTIONS (*CONTINUED*) | Yes | No |
|---|---|---|
| 25. Do you worry about your weight? | ☐ | ☐ |
| 26. Are you trying to or has anyone recommended that you gain or lose weight? | ☐ | ☐ |
| 27. Are you on a special diet or do you avoid certain types of foods or food groups? | ☐ | ☐ |
| 28. Have you ever had an eating disorder? | ☐ | ☐ |
| **FEMALES ONLY** | **Yes** | **No** |
| 29. Have you ever had a menstrual period? | ☐ | ☐ |
| 30. How old were you when you had your first menstrual period? | | |
| 31. When was your most recent menstrual period? | | |
| 32. How many periods have you had in the past 12 months? | | |

**Explain "Yes" answers here.**

**I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.**

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

## ■ PREPARTICIPATION PHYSICAL EVALUATION

# PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

### *PHYSICIAN REMINDERS*

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

| EXAMINATION | | |
|---|---|---|
| Height: Weight: | | |
| BP: / ( / ) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N | | |
| **MEDICAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Appearance<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) | ☐ | |
| Eyes, ears, nose, and throat<br>• Pupils equal<br>• Hearing | ☐ | |
| Lymph nodes | ☐ | |
| Heart[a]<br>• Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) | ☐ | |
| Lungs | ☐ | |
| Abdomen | ☐ | |
| Skin<br>• Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis | ☐ | |
| Neurological | ☐ | |
| **MUSCULOSKELETAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Neck | ☐ | |
| Back | ☐ | |
| Shoulder and arm | ☐ | |
| Elbow and forearm | ☐ | |
| Wrist, hand, and fingers | ☐ | |
| Hip and thigh | ☐ | |
| Knee | ☐ | |
| Leg and ankle | ☐ | |
| Foot and toes | ☐ | |
| Functional<br>• Double-leg squat test, single-leg squat test, and box drop or step drop test | ☐ | |

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

## ■ PREPARTICIPATION PHYSICAL EVALUATION

## MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

### SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____