

# Allegan Public Schools Pre-Participation Examination Form

## Student Information

Name:	Grade level in 2012-13:	
Birth Date:	Age:	Sex:
Address:	Phone #: (     )	
City:	Zip:	
Sport(s):		

## Emergency Contact Information

Father's/Guardian Name: \_\_\_\_\_  
 Phone (cell): \_\_\_\_\_ (work): \_\_\_\_\_ (home): \_\_\_\_\_  
 Mother's/Guardian Name: \_\_\_\_\_  
 Phone (cell): \_\_\_\_\_ (work): \_\_\_\_\_ (home): \_\_\_\_\_

## Emergency Information

Allergies – Drug Reactions – Current Medications: \_\_\_\_\_

Other Special Medical Information: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: (C) \_\_\_\_ - \_\_\_\_ - \_\_\_\_ (W) \_\_\_\_ - \_\_\_\_ - \_\_\_\_ (H) \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Personal Physician \_\_\_\_\_ Office Telephone \_\_\_\_ - \_\_\_\_ - \_\_\_\_

### 1. Insurance Waiver

Our son/daughter will comply with the specific insurance regulations of the school district.

The student-athlete has health insurance:      YES                      NO

➔ If yes, Family Insurance Company: \_\_\_\_\_ Contract #: \_\_\_\_\_

### 2. Medical Treatment Consent

In all cases of sickness or injury, school officials, coaches, or the athletic trainer will attempt to notify parents immediately. In instances when contact cannot be made with parent, decisions must be made concerning how to deal with emergency situations. You are requested to approve the following statement authorizing the emergency care of your athlete.

I, \_\_\_\_\_, the parent or guardian of \_\_\_\_\_, recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then-existing circumstances and to assume that expenses of such care.

Signature of Parent/Guardian: \_\_\_\_\_

➔ **OR (Sign only one)**

I prefer not to sign the above statement, but offer the following instructions for handling an emergency involving (print child's name) \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Instructions: \_\_\_\_\_  
 \_\_\_\_\_

### 3. Permission to Participate

Parents and student athletes should fully understand and appreciate the risks of serious personal injury associated with participation in the educational sports programs provided by the Allegan Public Schools. Participation in school activities involves flying objects, swift movement of bodies, which at times are airborne, and unavoidable collisions.

Athletic activities are hazardous and taking part in such activities is calculated risk-taking on the part of the student athlete and parents. It is also understandable, that to many young adults, the potential benefits of participation exceed the potential hazards. It is also the continuing goal of our coaching and administrative staff that injuries are kept to a minimum.

I have read the above warning statement and understand the risks involved in participation in athletic activities and have discussed these with my son/daughter.

I hereby give my consent for the above student to engage in interscholastic athletics and for the disclosure to the MHSAA of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics; and I understand the possibility that serious injury may result from participating in athletic activities. He/she has my permission to accompany the team as a member on it's out of town trips.

I further understand that my son or daughter will be expected to adhere firmly to all established athletic policies of the school district and the Michigan High School Athletic Association.


 **Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### 4. Student Disclosure and Acceptance of Conditions to Participate

This application to participate in athletics is voluntary on my part and the information submitted is truthful to the best of my knowledge.

I have never received money of negotiable certificate for merchandise in any amount, nor any emblematic award or merchandise worth more than twenty-five dollars (\$25.00) for participating in athletic events, nor have I ever used an assumed name. After I have represented my school in any sport, I will not compete in any outside athletic contest in this sport until after my school season has been completed.

I understand that I am expected to adhere firmly to all established athletic policies of my school district and the Michigan High School Athletic Association, such as those previously mentioned above as examples but which do not present all the policies to which I am subject.

 **Signature of STUDENT:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### PERMISSION FOR USE OF PRIVATE TRANSPORTATION

Due to cuts in the athletic budget, it is necessary to have parents and coaches transport athletes to and from most athletic contests. We understand this is neither the ideal, nor desirable situation, but need to do so under present circumstances. Please complete the following indicating your permission for your son/daughter to ride with a qualified driver.

I, \_\_\_\_\_, give my permission for (athlete's name) \_\_\_\_\_ to ride to and from contests with a legally licensed, insured adult driver whose name is on file with Allegan Public Schools. I understand that student-athletes will not be used to transport other student-athletes.

**Parent/Guardian Name (Printed)** \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

 **OR (Sign only one)**

I, \_\_\_\_\_, prefer that (child's name) \_\_\_\_\_ **NOT** ride with anyone other than his/her parent or coach.

**Parent/Guardian Name (Printed)** \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## Pre-Participation Examination Clearance Form

*This form must be on file in the athletic office before practicing with any athletic team  
The exam date must be performed on or after April 15<sup>th</sup> to be valid for the following school year*

I, \_\_\_\_\_, the parent or guardian of \_\_\_\_\_, give my permission for my athlete, named above, to receive a pre-participation exam from the medical professionals arranged for by the Allegan Athletic Department.



Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*This waiver must be signed for the medical professional to administer the exam.*

***The rest of this form is to be completed by the medical professional performing the exam.***

Student Name: \_\_\_\_\_

I certify that the above student has been medically evaluated and is deemed to be physically fit to: **(Check one box)**

(1) Participate in all school interscholastic activities without restrictions.

(2) Not cleared for:  All Sports  Specific Sports \_\_\_\_\_

**Cross out specific sports below not cleared for participation**

Sports classification based on contact:					
Collision Contact Sports		Limited Contact Sports		Non-contact Sports	
Basketball	Ice Hockey	Baseball	Alpine Skiing	Bowling	Track Running
Boys Lacrosse	Soccer	Competitive Cheer	Girls Softball	Cross Country	Track/Field
Diving	Wrestling	Girls Lacrosse	Track/Field Events	Golf	Events
Football		Girls Gymnastics	High Jump	Swimming	Discus
		Girls Volleyball	Pole Vault	Tennis	Shot Put

Sports classification based on intensity and strenuousness:					
High Intensity High-to-Moderate Dynamic High-to-Moderate Static		High Intensity High-to-Moderate Dynamic Low Static		High Intensity Low Dynamic High-to-Moderate Static	
Alpine Skiing	Track Events – Distance	Baseball	Swimming	Girls Competitive Cheer	Bowling
Cross Country	Track Events – Sprint	Lacrosse	Tennis	Diving	Golf
Football	Wrestling	Soccer	Girls Volleyball	Field Events	
Ice Hockey		Girls Softball		Girls Gymnastics	

(3) Requires further evaluation before a final recommendation can be made.

Additional recommendations for the school or parents: \_\_\_\_\_

***I have examined the above named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the athlete has been cleared for participation, the provider may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).***

Examiner Signature: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Print Examiner Name: \_\_\_\_\_

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

Office Telephone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**COPY BOTH SIDES OF THIS SHEET FOR THE STUDENT TO RETURN TO THE SCHOOL AND KEEP THE ENTIRE FORM IN THE STUDENTS MEDICAL RECORDS**

**PREPARTICIPATION PHYSICAL EVALUATION  
PHYSICAL EXAMINATION FORM**

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

**Immunizations:** Has the student-athlete received all ACIP-recommended vaccines? **YES** **NO**  
 Check the Michigan Care Improvement Registry (MCIR) for vaccination status: [www.mcir.org](http://www.mcir.org)

**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, 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 supplement?
  - 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 any supplements to help you gain or lose weight or improve your performance?
  - Do you wear a seatbelt, use a helmet and use condoms?
2. Please review questions on cardiovascular symptoms and family history (questions 5-16) with parent and/or student athlete

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male	<input type="checkbox"/> Female
BP / ( / )	Pulse	Vision R 20/	L 20/ Corrected Yes or No
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance <ul style="list-style-type: none"> <li>• Marfan stigmata (kyphoscoliosis, high-arched papate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</li> </ul>			
Eyes/Ears/Nose/Throat <ul style="list-style-type: none"> <li>• Pupils equal</li> <li>• Hearing</li> </ul>			
Lymph nodes			
Heart* <ul style="list-style-type: none"> <li>• Murmurs (auscultation standing, supine, +/- Valsalva)</li> <li>• Location of point of maximum impulse (PMI)</li> </ul>			
Pulses <ul style="list-style-type: none"> <li>• Simultaneous femoral and radial pulses</li> </ul>			
Lungs			
Abdomen			
Genitourinary (males only)**			
Skin <ul style="list-style-type: none"> <li>• HSV, lesions suggestive of MRSA, tinea corporis</li> </ul>			
Neurologic***			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			
Functional <ul style="list-style-type: none"> <li>• Duck-walk, single leg hop</li> </ul>			

\*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam  
 \*\*Consider GU exam if in private setting. Having third party present is recommended.  
 \*\*\*Consider cognitive evaluation or baseline neuropsychiatric testing if history of significant concussion.

# MEDICAL HISTORY

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

Date of Exam: \_\_\_\_\_

Student Name: \_\_\_\_\_

School: \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

**Medicines & Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

Do you have any allergies  Yes  No If yes, please identify specific allergy below.  
 Medicines  Pollens  Food  Stinging Insects

GENERAL QUESTIONS	YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	YES	NO
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	YES	NO
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	YES	NO
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that requires x-rays, MRI, CT scan, injections, therapy, a brace, a cast or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics or other assistive device?		
23. Do you 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 any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	YES	NO
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "Yes" answers here: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

→ Signature of Athlete \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

→ Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_