Appendix 2: Athletic Participation / Parental Consent / Physical Examination Form

Denbigh Baptist Christian School
Attn: Athletic Department
13010 Mitchell Point Road
Newport News, Virginia 23602
(757) 249-2654 / ad@dbcs4christ.com / www.dbcs4christ.com

Athletic Participation / Parental Consent / Physical Examination Form
Separate examination is required for each school year **JUL 1** of the current year through **JUN 30** of the succeeding year.

PART I – ATHLETIC PARTICIPATION

For School Year _____

Male _____
Female _____

Name: _____
(Last) (First) (Middle Initial)

Street Address: _____

City / Zip Code: _____

Name of Parents or Legal Guardian: _____

Address of Parents or Legal Guardian: _____
(Only if different than students above)

Date of Birth: _____

Place of Birth: _____

I understand that the individual eligibility requirements are outlined starting on page 5 of the DBCS Athletic Handbook. I also understand the medical requirements as outlined starting on page 6 of the DBCS Athletic Handbook and that a copy of the exam must be on file in the school office before the first practice for any sport.

Student-Athlete's Name:	_____	_____	_____
	Print	*Signature*	*Date*
Parent's Name:	_____	_____	_____
(Guardian)	*Print*	*Signature*	*Date*

PART II – MEDICAL HISTORY

This form must be completed by parent or guardian prior to the physical examination and should be taken with the 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:
___	___		Adrenaline _____
___	___		Inhalers _____
___	___		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? _____
___	___	15.	Hepatitis B Immunization Series? _____
		16.	DATE OF LAST TETNUS IMMUNIZATION? _____

Parent/Guardian Signature:_____

PART III -- PHYSICAL EXAMINATION

(To be completed and signed by examining physician)

NAME: _____ SCHOOL _____

HEIGHT_____WEIGHT _____ SEX _____ AGE_____

*Tanner Stage or Maturation Index_____ BP _____

*Percent Body Fat_____ *Pulse (rest) _____

(Exercise) _____

(Recovery) _____

*Vision: Corrected (L)_____(R)_____Both_____

Uncorrected (L)_____(R)_____Both_____

*Audiogram:_____ Cervical spine/neck_____

Back _____

Eyes_____ Shoulders _____

Ears_____ Arm/elbow/wrist/hand _____

Nose_____ Knees/hips_____

Throat_____ Ankles/feet_____

Teeth _____

Skin_____ Lab:

Lymphatic_____ *Urine _____

Lungs_____ *Hemoglobin or HCT _____

Heart_____ and/or Fe Stores _____

Abdomen_____

Genitalia/hernia

Peripheral pulses_____ ***WHEN MEDICALLY INDICATED**

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

_____ Full Participation _____ Limited Participation

_____ No Participation _____ Needs Additional Evaluation

If not full participation give reasons & 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 show an abnormal exercise testing:

_____

c. Other_____

Physician Signature_____,M.D.* Date_____

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

Physician Name (print)_____

Address _____

City/Zip Code _____

Telephone Number _____

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 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 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.

I also give my consent and approval for my child/ward to receive a physical examination, as required in Part III, Physical Examination, of this form, by_____ M.D., D.O. or LNP as recommended by the named student's school administration.

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**_____
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._____
_____
Has student been prescribed an inhaler or epipen?_____
Is student presently taking medication?_____If so, what type?_____
Does student wear contact lenses?_____ Please list date of last 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) _____

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_____

Revised March 20, 2003 Parent/Guardian Signature