

FAITH BAPTIST SCHOOL
Athletic Participation/Parental Consent/Physical Examination Form

Separate examination is required for each school year **June 1st** of the current year through **May 30th** of the succeeding year.

PART I - ATHLETIC PARTICIPATION

(To be filled in and signed by the student)

Name _____ School Year _____
(Last) (First) (Middle Initial)

Home Address _____

City/Zip Code _____

Home Address of Parents _____

City/Zip Code _____

Date of Birth Place of Birth _____

I have read the condensed individual eligibility rules of Faith Baptist Schools that appear below and believe I am eligible to represent my present high school in athletics.

INDIVIDUAL ELIGIBILITY RULES

Academic ineligibility is determined as follows:

1. A student has two or more "F's."
2. A student has one "F" and an overall grade point average below 2.0.
3. A student has an overall grade point average below 2.0.

Eligibility is determined three times during each quarter, Eligibility is determined at each Edline posting of grades and using the results of the nine-week report card. Semester and exam grades are not used for determining eligibility. Eligibility affects student participation in athletics, student council, and other school-related organizations and extra-curricular activities. Students who earn a minimum of 40 demerits are subject to probation penalty (see Junior and Senior High Discipline). Students who are tardy on the day of a game must report to school by 12:00 noon or they will not be eligible to play that day's game.

Students who earn a minimum of 40 demerits are subject to probation penalty (see Junior and Senior High Discipline).

Student Signature: _____ Date: _____

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, soccer, softball, volleyball.

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. I will not hold school authorities responsible in case of accident or injury as a result of this participation. 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.

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

Parent Signature: _____ Date: _____

Parent Emergency Contact Number(s): _____

PART II - - MEDICAL HISTORY

This form must be completed and signed, prior to the physical examination, for review by examining physician. Explain "Yes" answers below with number of the question. Circle questions you don't know the answers to.					
MEDICAL HISTORY OF STUDENT & FAMILY			MEDICAL HISTORY OF STUDENT & FAMILY		
	Yes	No		Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	32. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	33. Have you ever had herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or non prescription (over the counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	34. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have allergies to medicines, pollens, foods or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	35. Date of last head injury or concussion: Date: _____		
5. Do you have prescriptions for use of epinephrine, adrenalin, inhaler, or other allergy medications?	<input type="checkbox"/>	<input type="checkbox"/>	36. Have you ever been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever passed out or nearly passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	37. Have you ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever passed out or nearly passed out at any other time?	<input type="checkbox"/>	<input type="checkbox"/>	38. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	39. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had to stop running after ¼ to ½ mile for chest pain or shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	40. Have you ever had a numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
10. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	41. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has a doctor ever told you that you have (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			42. When exercising in heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
			43. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
12. Has a doctor ever ordered a test for your heart?	<input type="checkbox"/>	<input type="checkbox"/>	44. Have you had any other blood disorders or anemia?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has anyone in your family died suddenly for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	45. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
14. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	46. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
15. Has any family member or relative died of heart problems or sudden death before age 50? (This does not include accidental death)	<input type="checkbox"/>	<input type="checkbox"/>	47. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
16. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	48. Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	49. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	50. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?	<input type="checkbox"/>	<input type="checkbox"/>	51. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you had any broken or fractured bones or dislocated joints?	<input type="checkbox"/>	<input type="checkbox"/>	52. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?	<input type="checkbox"/>	<input type="checkbox"/>	53. What is the date of your last Tetanus immunization? Date: _____		
			FEMALES ONLY 54. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	55. Age when you had your first menstrual period? _____		
23. 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?	<input type="checkbox"/>	<input type="checkbox"/>	56. How many periods have you had in the last 12 months? _____		
24. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	57. Do you take a calcium supplement?	<input type="checkbox"/>	<input type="checkbox"/>
25. Have you ever been diagnosed with asthma or other allergic disorders?	<input type="checkbox"/>	<input type="checkbox"/>	Explain "Yes" answers here:		
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>			
27. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>			
28. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>			
29. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>			
30. Have you had infectious mononucleosis (mono) within the last three months?	<input type="checkbox"/>	<input type="checkbox"/>			
31. Have you ever had mono or any illness lasting more than two weeks?	<input type="checkbox"/>	<input type="checkbox"/>			

Parent/Guardian Signature: _____ Athlete's Signature: _____

PART III – PHYSICAL EXAMINATION

(Physical examination is required each school year after May 1 of the preceding school year and is good through June 30th of the current school year)**

NAME: _____ SCHOOL: _____

HEIGHT: _____	WEIGHT: _____	SEX: _____	AGE: _____	DOB: _____
*Tanner Stage or Maturation Index: (males only) _____			BP: _____	
*Percent Body Fat: _____			Pulse: *(rest) _____	
*Audiogram _____			*(Exercise) _____	
*Vision: Corrected (L) _____ (R) _____ (Both) _____			*(Recovery) _____	
Uncorrected (L) _____ (R) _____ (Both) _____			*FEV or Peak Flow (rest) _____	
* (Exercise) _____			* (Recovery) _____	
* (Recovery) _____			* (Exercise) _____	
* (Exercise) _____			* (Recovery) _____	

	N	ABNORMAL		N	ABNORMAL
Eyes			Cervical Spine/neck		
Ears			Back		
Nose			Shoulders		
Throat			Arm/elbow/wrist/hand		
Teeth			Knees/hips		
Skin			Ankle/feet		
Lymphatic			Marfan Screen		
Lungs			*Urine		
Heart			*Hemoglobin or HCT and or Iron stores		
Peripheral pulses			^Echocardiogram		
Abdomen			^Neuropsyc Testing		
Genitalia/hernia (male only)			^Pelvic Examination		

***WHEN MEDICALLY INDICATED**

(Physician judgment based on history, exam, and knowledge of other recent physical and laboratory evaluations)

^WITH SPECIAL INDICATIONS

(These studies may be recommended to the athlete because of history or physical findings and may or may not be required before making participation decision.)

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 **AFTER** further evaluation or treatment for: _____

Cleared for **Limited participation** (check and explain "reason" for all that apply):

Not cleared for (specific sports) _____

Cleared only for (specific sports) _____

Reason(s): _____

NOT CLEARED FOR PARTICIPATION: _____

Reason(s): _____

Other Recommendations: _____

Recommend close monitoring during early conditioning because of weight/fitness/other

Recommend restrictions or monitoring of weight loss or gain

Other _____

Reason(s): _____

Physician Signature: _____ * M.D. Date of Examination** _____
 *(MD, DO, LNP, PA)

Date Signed: _____

Examiner's Name and degree (print): _____ Phone Number _____

Address: _____ City _____ State _____ Zip _____