



WEST FORSYTH HIGH SCHOOL

2010 – 11 PHYSICAL FORM



FORSYTH COUNTY SCHOOL SYSTEM ATHLETIC PARTICIPATION FORM

FORSYTH COUNTY ATHLETICS	PERMISSION FORM
Student – Athlete: (Please Print)	Name of Parent/Guardian: (Please Print)
Street Address:	School: Grade: CIRCLE ONE 7 8 9 10 11 12
City: State: Zip:	Date of Birth: Phone: Home – Work –

In the event of emergency, please give the best person and method to contact in the box provided.

Name:	Relationship:	Phone #:	Alt #:
<p>Request for Permission: We, the undersigned student and the student's parent/guardian, apply for permission to participate in interscholastic athletics in the following sport(s):</p>			
<input type="checkbox"/> Baseball / Softball	<input type="checkbox"/> Cross Country	<input type="checkbox"/> Lacrosse	<input type="checkbox"/> Tennis
<input type="checkbox"/> Basketball	<input type="checkbox"/> Football	<input type="checkbox"/> Soccer	<input type="checkbox"/> Track & Field
<input type="checkbox"/> Cheerleading	<input type="checkbox"/> Golf	<input type="checkbox"/> Swimming	<input type="checkbox"/> Wrestling
<input type="checkbox"/> Other: _____			

General Requirements- We have read and discussed the general requirements for athletic eligibility. We understand that additional questions or specific circumstances should be directed to our student's coach, athletic director or principal. We understand that the FC Athletic Guidelines are available through the county website for review.

Risk of Injury- We acknowledge and understand that there is a risk of injury involved in athletic participation. We understand that the student-athlete will be under the supervision and direction of a FCSS athletic coach. We agree to follow the rules of the sport and the instructions of the coach in order to reduce the risk of injury to the student and other athletes. However, we acknowledge and understand that neither the coach nor FCSS can eliminate the risk of injury in sports. Injuries may and do occur. Sports injuries can be severe and in some cases may result in permanent disability or even death. We freely, knowingly, and willfully accept and assume the risk of injury that might occur from participation in athletics.

Release- In consideration of FCSS allowing the student-athlete to participate in athletics, we agree to release and hold FCSS, its athletic coaches and other employees free, harmless and indemnified from and against any and all claims, suits or causes of action arising from or out of any injury that the student-athlete may suffer from participation in athletics.

Insurance- FCSS requires parents to provide information pertaining to medical insurance coverage for all student athletes. Parents have the option to purchase school insurance (please see school athletic director) or to maintain coverage under parental insurance provider.

Check One: <input type="checkbox"/> School Accident Insurance <input type="checkbox"/> Name of Other Insurance Company	Policy No.
Address:	Group No.

CERTIFICATION AND MEDICAL AUTHORIZATION. We certify that all of the information provided by us on this form is correct. We agree to abide by state and local rules. If the student-athlete is injured while participating in athletics and FCSS is unable to contact the parent, we grant FCSS permission and authority to obtain necessary medical care and/or treatment for the student's injury. Treatment may include, but is not limited to first aid, CPR, medical or surgical treatment recommended by a physician. We accept the financial responsibility for such medical care or treatment.

We, the undersigned student and parent, have read this document and understand all of the expectations for athletic participation at my school.

Student:	Date:
Parent/Guardian Signature:	Date:

“BLANKET” PERMISSION TO PARTICIPATE IN A SERIES OF SCHOOL SPONSORED FIELD TRIPS

Sport: _____ School Year: _____ School: _____

I hereby request that _____ (Student’s Name-PLEASE PRINT): be allowed to participate in athletic team, band, orchestra, chorus, and/or any series of field trips related to one particular area of study or activity. I understand that transportation may or may not be provided by the Forsyth County School District (District). In the event transportation is not provided by the District, transportation will be the parent’s responsibility.

All team members will ride to an event in school provided transportation with the team. Any athlete who arranges independent transportation to an event, without permission from the coach and the Athletic Director in advance, will be ineligible to compete in that event. All team members will return to their High School in the Forsyth County provided transportation unless a Travel Release form is completed by a parent/guardian (see the head coach). Athletes will only be released to their own parent/guardian from a contest. A parent/guardian must sign out the athlete from the coach at the contest site. If a student and his/her parent makes arrangements for private transportation, they shall not hold the local school, officers, employees or agents responsible for any injury or loss.

Detailed trip information, including destination, date, time of departure, time of return, purpose, and supervision, will be given to the parents/guardians prior to each trip in the series (Exceptions must be approved by the School Director of Athletics and Principal).

If any emergency medical procedures or treatment are required by the student during the trip, I consent to the trip supervisor(s) taking, arranging for, and consenting to the procedures or treatment in his/her or their discretion.

In consideration of FCSS allowing the student-athlete to participate in athletics, we agree to release and hold FCSS, its athletics coaches and other employees free, harmless, and indemnified from and against any and all claims, suits or causes of action arising from or out of any injury that the student-athlete may suffer from participation in athletics.

NOTE: This form must be signed by student if the student is 18 years of age or older.

Name of Student (PLEASE PRINT)

Signature of Student

Date

Name of Parent/Guardian (PLEASE PRINT)

Signature of Parent/Guardian

Date

DRIVING WAIVER

THIS SECTION MUST BE COMPLETED BY THE PARENT

NAME OF STUDENT LISTED ABOVE

All team members will ride to an event in school provided transportation with the team. Any athlete who arranges independent transportation to an event, without permission from the coach and the Athletic Director in advance, will be ineligible to compete in that event. All team members will return to their High School in the Forsyth County provided transportation unless a travel release form is completed by a parent/guardian. Athletes will only be released to their own parent/guardian from a contest. A parent/guardian must sign out the athlete from the coach at the contest site. If a student and his/her parent makes arrangements for private transportation, they shall not hold the local school, officers, employees or agents responsible for any injury or loss.

TRAVEL RELEASE FORM – I give my son/daughter permission to ride with an adult chaperone to/from an activity of West Forsyth High School during the school year. I further understand that I am releasing the school & its staff from my responsibility for any accident that might occur. I also give permission for medical treatment should it be needed.

PARENT / GUARDIAN SIGNATURE

DATE

Preparticipation Physical Evaluation

HISTORY FORM

Date of Exam _____

Name _____ Sex _____ Age _____ Date of birth _____

Grade _____ School _____ Sport(s) _____

Address _____ Phone _____

Personal Physician _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ Phone(W) _____

**Explain "Yes" answers below.
Circle questions you don't know the answers to.**

	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"/>		24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>																
2. Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>		25. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>																
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>		26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>																
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>		27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>																
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>		28. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>																
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>		29. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>																
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>		30. Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>																
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>		31. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>																
9. Has a doctor ever told you that you have (check all that apply):				32. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>																
<input type="checkbox"/> High blood pressure				33. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>																
<input type="checkbox"/> High cholesterol				34. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>																
<input type="checkbox"/> A heart murmur				35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>																
<input type="checkbox"/> A heart infection				36. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>																
10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>		37. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>																
11. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>		38. 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. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>		39. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>																
13. Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>		40. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>																
14. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>		41. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>																
15. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>		42. Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>																
16. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>		43. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>																
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below:	<input type="checkbox"/>	<input type="checkbox"/>		44. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>																
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>		45. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>																
19. 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? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>		46. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>																
<table border="1" style="font-size: small;"> <tr> <td>Head</td><td>Neck</td><td>Shoulder</td><td>Upper Arm</td><td>Elbow</td><td>Forearm</td><td>Hand/Fingers</td><td>Chest</td> </tr> <tr> <td>Upper Back</td><td>Lower Back</td><td>Hip</td><td>Thigh</td><td>Knee Shin</td><td>Calf/</td><td>Ankle</td><td>Foot/Toes</td> </tr> </table>	Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/Fingers	Chest	Upper Back	Lower Back	Hip	Thigh	Knee Shin	Calf/	Ankle	Foot/Toes				FEMALES ONLY		
Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/Fingers	Chest															
Upper Back	Lower Back	Hip	Thigh	Knee Shin	Calf/	Ankle	Foot/Toes															
20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>		47. Have you ever had a menstrual period?																		
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>		48. How old were you when you had your first menstrual period? _____																		
22. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>		49. How many periods have you had in the last 12 months? _____																		
23. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>		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 _____ Signature of Parent/Guardian _____ Date _____

Preparticipation Physical Evaluation

PHYSICAL EXAMINATION FORM

Name _____ Date of Birth _____

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP _____ / _____ (_____ / _____, _____ / _____)

Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
NORMAL			
Appearance			
Eyes/nose/ear/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only.
 +Having a third party present is recommended for the genitourinary examination.

Notes: _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

Preparticipation Physical Evaluation

CLEARANCE FORM

Name _____ Sex _____ Age _____ Date of birth _____

- Cleared without restriction
- Cleared, with recommendations for further evaluation or treatment for: _____

Not Cleared for All sports Certain sports: _____ Reason: _____

Recommendations: _____

EMERGENCY INFORMATION

Allergies _____

Other Information _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

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Preparticipation Physical Evaluation

CLEARANCE FORM

Name _____ Sex _____ Age _____ Date of birth _____

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Not Cleared for All sports Certain sports: _____ Reason: _____

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EMERGENCY INFORMATION

Allergies _____

Other Information _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

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