Evaluation for Participation in Sports

Pre-Participation Health Examination Record

Last Name	First Name	Middle Initial	School	Grade

Age __________ Date of Birth___________ Sex: _____Male ____ Female

This application to compete in interscholastic/community school athletics is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the State Association.

______________________ ____

Date Signature of Student

PARENT CONSENT CERTIFICATE

In accordance with the purpose and spirit of the P.I.A.A. By-Laws, Article IV, Section I. " A pupil shall be eligible for practice or participation in each sport only when there is on file with the principal a certificate of consent which is signed by student's parent or guardian." I give my consent for ____, a pupil of the Central Bucks School District, to take part in any athletic contests/community school athletics during the 20____ / 20_____ school year.

(Initial only the sports in which you wish your child to participate)

_____________________**Summer Camps**

PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE

I hereby give my consent for the above named student to represent his or her school/community school in athletic activities except those indicated on this form by the examining physician, provided that such activities are approved by the State Association. I also give my consent for the student to accompany the school team on any of its local or out-of-town trips.

The Central Bucks School District has no responsibility to provide first aid at any of the games/community school athletics and the parents or guardian understands that the risk of injury is assumed by the student and parent when they sign this form. However, in the event physicians, physical therapists, physician's assistants, nurses, or other persons trained in the rendering of first aid are available, as volunteers or otherwise, and render aid to any student injured during the course of any such activities or travel, the parents do hereby release and forever discharge such persons and the Central Bucks School District from any liability arising out of any first aid or immediate treatment of injuries.

____________________________________ ____

Typed or Printed Name of Parent or Guardian Signature of Parent or Guardian

____________________________________ ____________________________ ______________________

Address Phone Date

Central Bucks School District

STATEMENT REGARDING ACCIDENT INSURANCE WAIVER

We/I the undersigned are completely aware that the Central Bucks School District, Central Bucks Community School and Central Bucks Community Aquatic Club (CBAC) **DO NOT** provide accident insurance for ANY child or adult participating in the aquatics programs offered by Central Bucks Community School and assumes **NO LIABILITY** for injuries sustained from participation. We/I, the undersigned, further acknowledge and agree that neither the School District, the Community School or the CBAC, will assume any liability for any injuries sustained by participation in the program. We herein release the School District, the Community School, the CBAC, its agents, representatives, employees and the like from any and all liability related to the participation in the programs offered by the School District and Community School.

____ ____________________________________

Signature Relationship

____ ____________________________________

Signature Relationship

CB430 rev. 09.04

PIAA – BY- LAW Article V – Section I, Physical Examination Necessary Before Pupil Begins Practice

No pupil shall be eligible to represent his/her high school in any interscholastic contest/community school physical activity unless he/she has been examined by a licensed physician of medicine of osteopathic medicine, a certified school nurse practitioner, or physician assistant before his/her first sports season of that academic year. Before each subsequent sports season of the same academic year, he/she shall be re-examined or certified by a

licensed physician of medicine or osteopathic medicine, certified school nurse practitioner, or physician assistant that his/her condition is satisfactory before he/she commences to train or practice the intended sport.

THIS SECTION IS TO BE FILLED OUT BY PARENT

<u>Have you had or do you now have:</u>	NO	YES	EXPLAIN
1. Brain concussion (head injury)			
2. Convulsion or epilepsy			
3. Neck injury			
4. Impaired vision in either eye			
5. Chest pain with exertion or unexplained shortness of breath			
6. Hearing loss			
7. (Boys) Loss of function of testicle			
8. (Girls) Is there a problem with irregular menstrual periods?			
9. Bone fracture			
10. Joint dislocation			
11. Orthopedic or sports injury			
12. Diabetes			
13. Asthma			
14. Allergy			
15. Heart trouble or murmur			
16. High blood pressure			
17. Need for daily medication			
18. Need for **emergency** medication			
19. Congenital abnormalities			
20. HIV Positive			
21. Surgery			
22. Overnight hospitalization			
23. Fainting or lost consciousness during exercise			
24. An immediate family member diagnosed with heart disease. I.E. an abnormal heart rate, heart attack, had an angioplasty or bypass, cardiomyopathy, Marfan Syndrome, long QT Syndrome.			

Over the next 12 months I wish to participate in the following sports:

a) ______________________________________

b) ______________________________________

c) ______________________________________

By executing this document, we acknowledge and agree that to the best of our knowledge there is nothing that we are aware of that would preclude our child's participation in sports. We acknowledge that participation in sports can result in physical contact, exertion, injuries, and any other consequences of participation.

Parent or Guardian's Signature ____ **Date** ____________

The undersigned herein acknowledges and agrees that the parent or guardian has accurately completed the form to the best of the undersigned's knowledge information and belief.

Physician's Signature: ____ **Date**___________________

PHYSICAL EXAMINATION RECORD

Name________________________________ Date _________________ Age______________ Birthdate_________________

Height________________________ Vision: R______/_________, Corrected________, Uncorrected________

Weight________________________ L______/_________, Corrected________, Uncorrected________

Hearing: Normal ___________ Abnormal____________

Pulse____________________ Blood Pressure_________________ Min. Weight (Wrestling) ________________________

Update immunizations: _______DT ________Polio ________ MMR

	Normal	Abnormal Findings	Initials
1. Eyes			
2. Ears, Nose, Throat			
3. Mouth & Teeth			
4. Neck			
5. Cardiovascular			
6. Lungs			
7. Abdomen			
8. Skin			
9. Genitalia – Hernia (Male)			
10. Musculoskeletal; ROM, strength, etc.			
a) Neck			
b) Spine			
c) Shoulders			
d) Arms/hands			
e) Hips			
f) Thighs			
g) Knees			
h) Ankles			
i) Feet			
11. Neuromuscular			
12. Physical Maturity (Tanner stage)	1. 2. 3. 4. 5.		

Comments re: Abnormal Findings: ____

____

____

PARTICIPATION RECOMMENDATION:

Physicians Stamp Required

1. No participation in: ____
2. Limited participation in: ____
3. Requires: ____
4. Full participation in: ____

Physician's Signature: __________________________ Physician's Printed Name: _______________________ Date:________

Phone Number ______________________ Address____

Last Name	First Name	Middle Initial	School	Grade

INTERIM HEALTH HISTORY

This form should be used during the interval between participation evaluations. Positive responses should prompt a medical evaluation.

1. Have you missed more than 3 consecutive days of participation in usual activities because of an injury this past year? ____Yes ____No
2. Have you missed more than 5 consecutive days of participation in usual activities because of an illness, or have you had a medical illness diagnosed that has not been resolved in the past year? ____Yes ___ No
   If yes, please indicate type of illness____________________
3. Have you had a seizure, concussion or been unconscious for any reason in the last year? ____Yes ___ No
4. Have you had surgery or been hospitalized in the past year? ____Yes ___ No
   If yes, please indicate: Reason for hospitalization ____________________
   Type of surgery____________________
5. List all medication you are presently taking and what condition the medicine is for.
   a) ____________________
   b) ____________________
   c) ____________________

Physicians Stamp Required

6. Are you worried about any problem or condition at this time? ____Yes ___ No
   If yes, please explain: ____________________

____

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

____________________ Signature of athlete ____________ Date

____________________ Signature of parent ____________ Date

RECERTIFICATION

Physician's Signature____________________

Winter___ Date_________ Spring ____ Date___________

INTERIM HEALTH HISTORY

This form should be used during the interval between participation evaluations. Positive responses should prompt a medical evaluation.

1. Have you missed more than 3 consecutive days of participation in usual activities because of an injury this past year? ____Yes ____No
2. Have you missed more that 5 consecutive days of participation in usual activities because of an illness, or have you had a medical illness diagnosed that has not been resolved in the past year? ____Yes ___ No
   If yes, please indicate type of illness____________________
3. Have you had a seizure, concussion or been unconscious for any reason in the last year? ____Yes ___ No
4. Have you had surgery or been hospitalized in the past year? ____Yes ___ No
   If yes, please indicate: Reason for hospitalization ____________________
   Type of surgery ____________________
5. List all medication you are presently taking and what condition the medicine is for.
   a) ____________________
   b) ____________________
   c) ____________________

Physicians Stamp Required

6. Are you worried about any problem or condition at this time? ____Yes ___ No
   If yes, please explain____________________

____

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

____________________ Signature of athlete ____________ Date

____________________ Signature of parent ____________ Date

RECERTIFICATION

Physician's Signature: ____________________

Winter___ Date_________ Spring ____ Date___________