ATHLETIC PARTICIPATION FORM

Westside High School
Westside Middle School

Date: _____ Sport(s): _____

Directions: Fill out all information found on both pages of this form. Any missing information or signatures may keep the student from participation. This form must be on file in the athletic director's office before a student is allowed to participate in athletic activities.

Last Name	First Name		Birthdate	Sex
Address, City, Zip	Phone	Grade	Homeroom Teacher	Counselor
Parent/Guardian Names	Daytime Phone Numbers		Cell Phone Numbers	
Emergency Contact	Phone Number		Physician's Name & Phone	

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

		Yes	No
1	Has a doctor ever denied or restricted your Participation in sports for any reason?	Y	N
2	Do you have an ongoing medical condition (like diabetes or asthma)?	Y	N
3	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	Y	N
4	Do you have allergies to medicines, pollens, foods, or stinging insects?	Y	N
5	Have you ever passed out or nearly passed out DURING exercise?	Y	N
6	Have you ever passed out or nearly passed out AFTER exercise?	Y	N
7	Have you ever had discomfort, pain, or pressure in your chest during exercise?	Y	N
8	Does your heart race or skip beats during exercise?	Y	N
9	Has a doctor ever told you that you have (circle all that apply): High blood pressure, A heart murmur, High cholesterol, A heart infection		
10	Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	Y	N
11	Has anyone in your family died for no apparent reason?	Y	N
12	Does anyone in your family have a heart problem?	Y	N
13	Has any family member or relative died of heart problems or of sudden death before age 50?	Y	N
14	Does anyone in your family have Marfan syndrome?	Y	N
15	Have you ever spent the night in a hospital?	Y	N
16	Have you ever had surgery?	Y	N
17	Have you ever had an injury, like a sprain, muscle or ligament tear or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:		
18	Have you had any broken or fractured bones, or dislocated joints? If yes, circle below:		
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:		

Head	Neck	Shoulder	Upper arm	Elbow	Fore-arm	Hand/ finger	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/ shin	Ankle	Foot/toe

20	Have you ever had a stress fracture?	Y	N
21	Do you regularly use a brace or assistive device?	Y	N
22	Has a doctor ever told you that you have asthma or allergies?	Y	N
23	Do you cough, wheeze, or have difficulty breathing during or after exercise?	Y	N
24	Is there anyone in your family who has asthma?	Y	N
25	Have you ever used an inhaler or taken asthma medicine?	Y	N
26	Have you had infectious mononucleosis (mono) within the last month?	Y	N
27	Do you have any rashes, pressure sores, or other skin problems?	Y	N
28	Have you ever had a head injury or concussion?	Y	N
29	Have you been hit in the head and been confused or lost your memory?	Y	N
30	Have you ever had a seizure?	Y	N
31	Do you have headaches with exercise?	Y	N
32	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	Y	N
33	Have you ever been unable to move your arms or legs after being hit or falling?	Y	N
34	When exercising in the heat, do you have severe muscle cramps or become ill?	Y	N
35	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	Y	N
36	Have you had any problems with your eyes or vision?	Y	N
37	Do you wear glasses or contact lenses?	Y	N
38	Do you wear protective eyewear, such as goggles or a face shield?	Y	N
39	Do you have any concerns that you would like to discuss with a doctor?	Y	N

FEMALES ONLY

40	Have you ever had a menstrual period?	Y	N
41	How old were you when you had your first menstrual period? _____		
42	How many periods have you had in the last year? _____		

Explain "Yes" answers here: _____
_____
_____
_____
_____
_____

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

Athlete Signature _____ Parent/Guardian Signature_____ Date_____

SPORTS PHYSICAL EVALUATION FORM

To Be Filled Out By the Medical Professional:

Name _____ Date of Birth _____

Height _____ Weight _____ Pulse_____ BP____/_____ (_____/____, ___/_____)

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

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Skin			
Hernia			
MUSCULOSKELETAL			
Neck			
Back/Scoliosis			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only.

Notes:

_____
_____
_____

EMERGENCY INFORMATION

Allergies_____

Other Information_____

Name of physician (print/type)_____**Date**_____

Address _____ **Phone**_____

Signature of physician_____**, MD or DO**

CLEARED FOR SPORTS YES NO