STUDENT ATHLETE REGISTRATION PACKET

Section I: Student Information

Name: _____ Grade: _____
Last First Middle Initial

Student ID: _____ Birth Date: _____ Gender: ☐ Female ☐ Male ☐ Other

Home Address: _____
Address Line City/State Zip

Parent/Guardian #1 Name: _____ Contact Number: _____

Parent/Guardian #2 Name: _____ Contact Number: _____

School Attended Last Year: _____
School Name City/State

Private School Student: ◯ Yes ◯ No If yes, school name: _____

Section II: Medical Information & Medical Emergency Authorization

Family Doctor: _____ Contact Number: _____

Preferred Hospital: _____ Contact Number: _____

Medications in Use: _____ List all allergies: _____

Emergency Contact: _____ Contact Number: _____

Relationship: _____

Name of Student Athlete: _____ School: _____

I hereby grant permission to the Athletic Trainer Sports Service Provider and Team Physicians, or other physicians designated by the above named school and Parent/Guardian to provide my child with any medical care or surgical care that they deem reasonably necessary to my child's health and well-being as a result of injuries or other medical conditions occurring as the result of or during athletic activities.

I further authorize the Athletic Trainer Sports Service Providers who are under the direction and guidance of a physician to provide my child with any preventive, first - aid, rehabilitative or emergency treatment they deem reasonably necessary to my child's health and well-being as a result of injuries or other medical conditions occurring as the result of/or during athletic activities.

If reasonably necessary to provide the care described in the preceding two paragraphs, I grant permission to the Athletic Trainer Sports Service Provider and/or school officials to seek necessary treatment at a hospital or health care center.

☒ _____ Date: _____
Signature of Parent/Guardian

Section III: Parent Consent of Sport Injury Risk

Student may participate in a maximum of three (3) sports, one per sport season. Please indicate your choice(s) by placing a check mark in the box next to the selected sport(s). **Please attach Sport Risk/Injury Parent Consent forms to approve each chosen sport for your student:**

Fall:	☐ Cross Country	☐ Football	☐ Golf	☐ G. Soccer	☐ G. Swimming
	☐ Volleyball (HS)	☐ Ultimate Frisbee (MS)			
Winter:	☐ Basketball	☐ Gymnastics	☐ B. Swimming	☐ Wrestling	
Spring:	☐ Baseball	☐ B. Soccer	☐ Softball	☐ Tennis	☐ Track
	☐ Volleyball (MS)				
Other:	☐ (Please List:)				

Section IV: Mandatory Athletic Insurance

I understand that my student may not participate in boys' or girls' after-school athletics unless he/she is covered by the approved Seattle School District Athletic Insurance Program or by an equivalent plan which provides benefits for loss due to a covered injury with a minimum benefit of $25,000 for each injury including the following minimum provisions:

o Surgery	50% of usual and customary charges/$12,000 maximum
o Physician Visits	$40 per day for first visit and $25 for following visits
o Emergency Room	100%
o X-Rays	60% or up to $500
o MRI and CAT Scan	+80% or up to $500
o Dental	60%

Please check one of the options and then sign below

◯ Option 1: My student is currently enrolled in the approved Seattle School District Student Accident and Health Insurance Program.

OR

◯ Option 2: My student is covered by a plan that is equivalent or better than the above requirements and I will continue to keep it in force throughout the sports season; therefore, I do not wish to enroll my student in the Seattle School District Athletic Insurance Program (high school) or the Seattle School District regular school insurance program (middle school).

_____ _____

Name of Company Providing Coverage | Policy Number or Employee Name

☒ _____ Date: _____

Signature of Parent/Guardian

Section V: Physical Examination

Washington Interscholastic Activities Association (WIAA) regulation 18.13.0 requires that prior to the first practice for participation in interscholastic athletics a student shall undergo a thorough medical examination and be approved for middle level and/or high school interscholastic athletic competition by a medical authority licensed to perform a physical examination.
This physical examination must include, but is not necessarily limited to:

- o Documentation of a detailed review of the student's medical history with special attention to presence or absence of cardiovascular/pulmonary risks and/or previous significant injury and rehabilitation there from.
- o Documentation of satisfactory examination of the cardiopulmonary system.
- o Documentation of satisfactory sport - specific orthopedic screening examination.
- o A written statement by the examiner as to the fitness of the student to undertake the proposed athletic participation, together with suggestions for activity modification if necessary.

WIAA regulation 18.13.5 states that for each subsequent twenty - four **consecutive** months, the student shall furnish a statement or physical examination form signed by a medical authority licensed to perform a physical examination that provides clearance for continued athletic participation.

☒ _____ Date: _____

Signature of Parent/Guardian

The Seattle School District provides Equal Educational and Employment Opportunity without regard to race, creed, color, national origin, sex, handicap/disability or sexual orientation.

If you have questions regarding the school district's Affirmative Action Policy, call 206-252-0371

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

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

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	◯	◯
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____	◯	◯
3. Have you ever spent the night in the hospital?	◯	◯
4. Have you ever had surgery?	◯	◯
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?	◯	◯
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	◯	◯
7. Does your heart ever race or skip beats (irregular beats) during exercise?	◯	◯
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____	◯	◯
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)	◯	◯
10. Do you get lightheaded or feel more short of breath than expected during exercise?	◯	◯
11. Have you ever had an unexplained seizure?	◯	◯
12. Do you get more tired or short of breath more quickly than your friends during exercise?	◯	◯
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?	◯	◯
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?	◯	◯
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	◯	◯
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	◯	◯
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?	◯	◯
18. Have you ever had any broken or fractured bones or dislocated joints?	◯	◯
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?	◯	◯
20. Have you ever had a stress fracture?	◯	◯
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)	◯	◯
22. Do you regularly use a brace, orthotics, or other assistive device?	◯	◯
23. Do you have a bone, muscle, or joint injury that bothers you?	◯	◯
24. Do any of your joints become painful, swollen, feel warm, or look red?	◯	◯
25. Do you have any history of juvenile arthritis or connective tissue disease?	◯	◯

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	◯	◯
27. Have you ever used an inhaler or taken asthma medicine?	◯	◯
28. Is there anyone in your family who has asthma?	◯	◯
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	◯	◯
30. Do you have groin pain or a painful bulge or hernia in the groin area?	◯	◯
31. Have you had infectious mononucleosis (mono) within the last month?	◯	◯
32. Do you have any rashes, pressure sores, or other skin problems?	◯	◯
33. Have you had a herpes or MRSA skin infection?	◯	◯
34. Have you ever had a head injury or concussion?	◯	◯
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?	◯	◯
36. Do you have a history of seizure disorder?	◯	◯
37. Do you have headaches with exercise?	◯	◯
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	◯	◯
39. Have you ever been unable to move your arms or legs after being hit or falling?	◯	◯
40. Have you ever become ill while exercising in the heat?	◯	◯
41. Do you get frequent muscle cramps when exercising?	◯	◯
42. Do you or someone in your family have sickle cell trait or disease?	◯	◯
43. Have you had any problems with your eyes or vision?	◯	◯
44. Have you had any eye injuries?	◯	◯
45. Do you wear glasses or contact lenses?	◯	◯
46. Do you wear protective eyewear, such as goggles or a face shield?	◯	◯
47. Do you worry about your weight?	◯	◯
48. Are you trying to or has anyone recommended that you gain or lose weight?	◯	◯
49. Are you on a special diet or do you avoid certain types of foods?	◯	◯
50. Have you ever had an eating disorder?	◯	◯
51. Do you have any concerns that you would like to discuss with a doctor?	◯	◯
FEMALES ONLY		
52. Have you ever had a menstrual period?	◯	◯
53. How old were you when you had your first menstrual period?	◯	◯
54. How many periods have you had in the last 12 months?	◯	◯

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 _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height _____ Weight _____	☐ Male ☐ Female	
BP _____ / _____ (_____ / _____) Pulse _____	Vision R 20/ _____ L 20/ _____	Corrected ☐ Y ☐ N
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____
- Reason _____

Recommendations _____

_____

_____

_____

_____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

EMERGENCY INFORMATION

Allergies _____

_____

_____

_____

_____

_____

Other information _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____