FCPS MIDDLE SCHOOL SPORTS ATHLETIC PARTICIPATION/PARENTAL CONSENT/PHYSICAL EXAMINATION FORM

Separate signed form is required for each school year **MAY 1** of the current year through **JUNE 30** of the succeeding year.

For school year_____ **PART I- ATHLETIC PARTICIPATION** Male___

(To be filled in and signed by the student) Female___

PRINT CLEARLY

Name _____ Student ID#_____

(Last) (First) (Middle Initial)

Home Address _____

City/Zip Code _____

Home Address of Parents _____

City/Zip Code _____

Date of Birth _____ Place of Birth _____

INDIVIDUALIZED ELIGIBILITY RULES

To be eligible to represent your school in any FCPS middle school interscholastic athletic contest, you:

- Must be a regular bona fide student in good standing of the school you represent.
- Must be currently enrolled in not fewer than five subjects, or their equivalent.
- As determined by the principal, eligible to participate in the middle school after-school program and middle school athletic program.
- Must have submitted to your principal before any kind of participation, including tryouts or practice as a member of any school athletic team, an Athletic Participation/Parent Consent/Physical Examination Form, completely filled in and properly signed attesting that you have been examined during this school year and found to be physically fit for competition and that your parents' consent to your participation.

Eligibility to participate in interscholastic athletics is a privilege you earn by meeting not only the above-listed minimum standards, but also all other standards set by FCPS and your school. If you have any question regarding your eligibility or are in doubt about the effect an activity might have on your eligibility, **check with your principal for interpretations.** Meeting the intent and spirit of these standards will prevent you, your team, school, and community from being penalized. Additionally, I give my consent and approval for my picture and name to be printed in any school or FCPS athletic program, publication or video.

EACH SCHOOL MAY REQUIRE ADDITIONAL STANDARDS TO THOSE LISTED ABOVE.

→Student Signature:_____ Date:_____

PROVIDING FALSE INFORMATION WILL RESULT IN INELIGIBILITY FOR ONE YEAR.

The pre-participation physical examination is not a substitute for a thorough annual examination by a student's primary care physician.

PART II- MEDICAL HISTORY (Explain "YES" answers below)

This form must be complete and signed, prior to the physical examination, for review by examining practitioner.
Explain "YES" answers below with number of the question. Circle questions you don't know the answers to.

GENERAL MEDICAL HISTORY	YES	NO
1. Do you have any concerns that you would like to discuss with your provider?	☐	☐
2. Has a provider ever denied or restricted your participation in sports for any reason?	☐	☐
3. Do you have any ongoing medical conditions? If so, please identify: ☐ Asthma ☐Anemia ☐Diabetes ☐ Infections ☐Other: _____	☐	☐
4. Are you currently taking any medications or supplements on a daily basis?	☐	☐
5. Do you have allergies to any medications?	☐	☐
6. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?	☐	☐
7. Have you ever spent the night in the hospital? If yes, why? _____	☐	☐
8. Have you ever had surgery?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**
9. Have you ever passed out or nearly passed out DURING or AFTER exercise?	☐	☐
10. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	☐	☐
11. Does your heart race, flutter in your chest or skip beats (irregular beats) during exercise?	☐	☐
12. Has a doctor ever ordered a test for your heart? For example, electrocardiography or echocardiography.	☐	☐
13. Has a doctor ever told you that you have any heart problems, including: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki Disease ☐ Other _____	☐	☐
14. Do you get light-headed or feel shorter of breath than your friends during exercise?	☐	☐
15. Have you ever had a seizure?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**
16. Does anyone in your family have a heart problem?	☐	☐
17. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (including drowning or unexplained car crash)?	☐	☐
18. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?	☐	☐
19. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	☐	☐
BONE AND JOINT QUESTIONS	**YES**	**NO**
20. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?	☐	☐
21. Do you currently have a bone, muscle or joint injury that bothers you?	☐	☐
MEDICAL QUESTIONS	**YES**	**NO**
22. Do you cough, wheeze or have difficulty breathing during or after exercise?	☐	☐
23. Do you have asthma or use asthma medicine (inhaler, nebulizer)?	☐	☐

MEDICAL QUESTIONS CONTINUED	YES	NO
24. Have you had mononucleosis (mono) within the last month?	☐	☐
25. Are you missing a kidney, eye, testicle, spleen or other internal organ?	☐	☐
26. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	☐	☐
27. Have you ever become ill while exercising in the heat?	☐	☐
28. When exercising in the heat, do you have severe muscle cramps?	☐	☐
29. Do you have headaches with exercise?	☐	☐
30. Have you ever had numbness, tingling or weakness in your arms or legs or been unable to move your arms or legs AFTER being hit or falling?	☐	☐
31. Do you or does someone in your family have sickle cell trait or disease?	☐	☐
32. Have you had any other blood disorders?	☐	☐
33. Have you had a concussion or head injury that caused confusion, a prolonged headache or memory problems?	☐	☐
34. Have you had or do you have any problems with your eyes or vision?	☐	☐
35. Do you wear glasses or contacts?	☐	☐
36. Do you wear protective eyewear like goggles or a face shield?	☐	☐
37. Do you worry about your weight?	☐	☐
38. Are you trying to or has anyone recommended that you gain or lose weight?	☐	☐
39. Do you limit or carefully control what you eat?	☐	☐
40. Have you ever had an eating disorder?	☐	☐
41. Are you on a special diet or do you avoid certain types of foods or food groups?		
42. Allergies to food or stinging insects?	☐	☐
43. Have you ever had a COVID-19 diagnosis? Date:	☐	☐
44. What is the date of your last Tdap or Td (tetanus) immunization? (circle type) Date: _____		
FEMALES ONLY	**YES**	**NO**
45. Have you ever had a menstrual period?	☐	☐
46. Age when you had your first menstrual period: _____		
47. Number of periods in the last 12 months: _____		
48. When was your most recent menstrual period? _____		

EXPLAIN "YES" ANSWERS BELOW

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List medications and nutritional supplements you are currently taking here:

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

PART III- PHYSICAL EXAMINATION

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

NAME_____ **DATE OF BIRTH**_____ **SCHOOL**_____

Height	Weight	☐ Male	☐ Female
BP /	Resting pulse	Vision R 20/ L 20/	Corrected ☐ Yes ☐ No

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance (Marfan stigmata: kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse, and aortic insufficiency)		
Eyes/ears/nose/throat (Pupils equal, hearing)		
Lymph nodes		
Heart (Murmurs: auscultation standing, supine, +/- Valsalva)		
Pulses		
Lungs		
Abdomen		
Skin (Herpes simplex virus, lesions suggestive of MRSA or tinea corporis)		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional (i.e. Double leg squat, single leg squat, box drop or step drop test)		
Emergency medications required on-site: ☐ Inhaler ☐ Epinephrine ☐ Glucagon ☐ Other:		
COMMENTS:		

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics:

☐ **MEDICALLY ELIGIBLE FOR ALL SPORTS WITHOUT RESTRICTION**

☐ **MEDICALLY ELIGIBLE FOR ALL SPORTS WITHOUT RESTRICTION WITH RECOMMENDATION FOR FURTHER EVALUATION OR TREATMENT OF:**

_____

☐ **MEDICALLY ELIGIBLE <u>ONLY</u> FOR THE FOLLOWING SPORTS:**_____

Reason:_____

☐ **<u>NOT</u> MEDICALLY ELIGIBLE PENDING FURTHER EVALUATION OF:** _____

☐ **<u>NOT</u> MEDICALLY ELIGIBLE FOR ANY SPORTS**

By this signature, I attest that I have examined the above student and completed this pre-participation physical including a review of Part II- Medical History.

→ **PRACTITIONER SIGNATURE:** _____ **(MD, DO, NP or PA)+ DATE**:** _____

EXAMINER'S NAME AND DEGREE (PRINT): _____ PHONE NUMBER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

+Only signature of Doctor of Medicine, Doctor of Osteopathic Medicine, Nurse Practitioner or Physician's Assistant <u>licensed to practice in the United States</u> will be accepted.

NOTE: When an out-of-jurisdiction student who has received a current athletic physical examination elsewhere transfers to FCPS and attaches proof of that physical examination to this form, the student is in compliance with physical examination requirements.

PART IV- ACKNOWLEDGEMENTS OF RISK AND INSURANCE STATEMENT

(To be completed by parent/guardian)

I give permission for _____ (name of child/ward) to participate in any of the following sports that are NOT crossed out: cross country, track.

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. He/she has student medical/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 medical insurance 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 participation in athletics/activities for his/her school during the school year covered by this form. I further consent to allow said physician(s) of 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.

Additionally, I give my consent and approval for the above-named student's picture and name to be printed in any school or FCPS athletic program, publication, or video.

To access quality, low-cost comprehensive health insurance through FAMIS for your child, please contact Cover Virginia by going to www.coverva.org or calling 855-242-8282.

PART V- EMERGENCY PERMISSION FORM*

(To be completed and signed by the parent/guardian)

STUDENT'S NAME: _____ GRADE: _____ AGE: _____ DOB: _____

MIDDLE SCHOOL: _____ CITY: _____

Please list and significant health problems that might be significant to a physician evaluating your child **in case of an emergency:**

_____

PLEASE LIST ANY ALLERGIES TO MEDICATIONS, ETC: _____

_____

IS THE STUDENT CURRENT PRESCRIBED AN INHALER OR EPI-PEN? _____ LIST THE EMERGENCY MEDICATION: _____

IS THE STUDENT PRESENTLY TAKING ANY OTHER MEDICATION? _____ IF SO, WHAT? _____

DOES THE STUDENT WEAR CONTACT LENSES? _____ DATE OF LAST Tdap OR Td (TETANUS) SHOT: _____

EMERGENCY AUTHORIZATION: In the event I cannot be reached in an emergency, I hereby give permission to physicians selected by the coaches and staff of _____ Middle School to hospitalize, secure proper treatment for and to order the injection and/or anesthesia and/or surgery for the person named above.

DAYTIME PHONE NUMBER (WHERE TO REACH YOU IN AN EMERGENCY): _____

EVENING TIME PHONE NUMBER (WHERE TO REACH YOU IN AN EMERGENCY): _____

CELL PHONE NUMBER: _____

→ SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

RELATIONSHIP TO STUDENT: _____

*Emergency Permission Form may be reproduced to travel with respective teams and is acceptable for emergency treatment if needed.

→ I CERTIFY ALL OF THE ABOVE INFORMATION IS CORRECT: _____

Parent/Guardian signature

The pre-participation physical examination is not a substitute for a thorough annual examination by a student's primary care physician.

FAIRFAX COUNTY PUBLIC SCHOOLS

EMERGENCY CARE INFORMATION

In case of an emergency, the school staff will contact 911.
Every attempt will be made to contact a parent, a guardian, or a designated emergency contact.

STUDENT INFORMATION

Last:	First:	Middle:	Date of Birth:	Gender: ☐ M ☐ F	Grade:
School Name:	ID No.:	Teacher or Counselor :		Bus # (AM):	Bus # (PM):
☐ Student has medical alert information on file. See page 2 for details.		Student Cell ______________			

PARENT/GUARDIAN CONTACT INFORMATION

This form is to be completed by the enrolling parent. The enrolling parent is the natural or adoptive parent or legal guardian with whom the student lives the preponderance of the school week and who enrolled the student in school.

Enrolling Parent Last:	First:	Middle:	Telephone Home:
Number: Street:		Apt.#:	Work:
City:	State:	Zip:	Cell:
Relationship: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Self	☑ Resides with	Language:	E-mail:

Other Parent Last:	First:	Middle:	Telephone Home:
Number: Street:		Apt.#:	Work:
City:	State:	Zip:	Cell:
Relationship:	☐ Resides with	Language:	E-mail:

Other Parent Last:	First:	Middle:	Telephone Home:
Number: Street:		Apt.#:	Work:
City:	State:	Zip:	Cell:
Relationship:	☐ Resides with	Language:	E-mail:

Other Parent Last:	First:	Middle:	Telephone Home:
Number: Street:		Apt.#:	Work:
City:	State:	Zip:	Cell:
Relationship:	☐ Resides with	Language:	E-mail:

OTHER CONTACT INFORMATION

Please list at least two people we may call if the parent(s) or guardian(s) cannot be reached in the event of an emergency. These people also have your permission to pick your child up from school during the school day.

Name of Person	Relationship	Language	Telephone

* Please remember to sign page 2.

FAIRFAX COUNTY PUBLIC SCHOOLS

EMERGENCY CARE INFORMATION

In case of an emergency, the school staff will contact 911.
Every attempt will be made to contact a parent, a guardian, or a designated emergency contact.

STUDENT INFORMATION

Last:	First:	Middle:	Date of Birth:	Gender: ☐ M ☐ F	Grade:

School Name:	ID No.:	Teacher or Counselor:	Bus # (AM):	Bus # (PM):

Siblings attending the same school (complete if applicable).

Name(s): _____

Name(s): _____

Primary Internet access in the home for this student is

☐ Cellular ☐ Broadband ☐ Other ☐ None ☐ Declined

Do you have a device for this student to use that meets their educational needs? ☐ Yes ☐ No ☐ Declined

CURRENT HEALTH CONDITIONS

Below check any current health condition(s) that EMS or an emergency room physician should know about health of your student. **Also complete and submit Health Information form SS/SE-71 if your child has a health condition(s) that require(s) attention during the school day. See below for medical alert information currently on file.**

☐ allergies (be specific)
- ☐ foods _____
- ☐ medicines _____
- ☐ bee sting or insect bite _____
- ☐ other _____

☐ asthma
☐ cancer
☐ diabetes
☐ hearing problems ☐ hearing aid(s)
☐ heart problems (be specific) _____

_____

☐ hemophilia ☐ sickle cell anemia
☐ physical disability (be specific)

_____

☐ respiratory (be specific)

_____

☐ seizures
☐ vision problems (be specific) _____
- ☐ glasses ☐ contacts

☐ other (be specific)

_____

_____

List all medications and dosages your child receives on a continual basis:

_____

_____

_____

MEDICAL ALERT INFORMATION ON FILE

This space reserved for system printing of Health Information

PHYSICIAN INFORMATION

My child's medical care is provided by: _____ (name of doctor, clinic, or HMO) _____ (telephone)

Does your child have health insurance? ☐ Yes ☐ No

If yes, medical coverage is provided by: _____ (health insurance company, assistance program, HMO, etc.) _____ (telephone)

First aid and emergency treatment will be provided to students in accordance with the current version of FCPS Regulation 2102 or in accordance with the student's individualized health plan.

ENROLLING PARENT OR GUARDIAN SIGNATURE: _____ DATE: _____