

LAST NAME: _____

FIRST NAME: _____ MID INIT: _____

YEAR IN

SCHOOL: (CIRCLE) FR SO JR SR

WILL GRADUATE IN JUNE: 2019 20 21 22 23

DATE OF BIRTH: MO-DY-YR

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PLACE OF BIRTH: _____

SEX: FEMALE MALE

PARENT/LEGAL GUARDIAN: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PRIMARY TELEPHONE: _____

SECONDARY TELEPHONE: _____

Name of emergency contact: _____

(In case parents cannot be reached)

TEL: _____

1. Have you ever represented another high school in an interscholastic activity? If yes, list schools & sports. _____
2. Have you ever played on or against a professional team or individual? _____
3. Have you ever accepted any article of compensation other than a school athletic award for participating in a sport? Explain: _____
4. Have you ever registered in a high school and withdrawn before the end of the semester? _____ If yes, where? _____ Why? _____
5. If any of the information on this form changes during the school year, please report the new information to the school immediately.
6. The information provided in completing this form is true and correct. Upon signing this eligibility form I realize that if I am ineligible, my school, the team, and I will suffer the consequences of my ineligibility.

Signature of Student

Date

APPROVAL: I understand that the Board of Education carries no athletic insurance and does not assume responsibility for injuries sustained in practice or games. If insurance coverage for injuries is desired, I recognize that such coverage is the responsibility of the parent. NOTE: Insurance protection is obtainable from private insurance companies or Healthy Kids of Oregon depending on income levels. Rates and injury information may be obtained free from your preferred medical provider.

- ☐ If your child/children do not have health coverage, check the box to be contacted by Healthy Kids of Oregon for NO to LOW cost health insurance for children 0 to 19 years old.

I approve the participation of my child in interscholastic athletics during his high school career, and authorize the school representative to administer essential first aid where necessary.

Parent/Guardian Signature(s)

Date

STATEMENT OF RISKS: PORTLAND PUBLIC SCHOOLS

Any sport, which may result in great exertion or contact with fixed or moving surfaces will contain inherent risks of serious bodily harm, which cannot be eliminated. The possibility of injuries from these dangers must be accepted by the player and the player's family.

The possibility of injury can be reduced, but not eliminated, by knowing and using proper techniques and fundamentals, maintaining good physical conditioning, being alert at all times and attending all training and practice sessions.

As a condition of permission to participate, player assures he/she will use proper techniques and fundamentals, maintain good physical conditioning, stay alert at all times, attend all training and practice sessions, follow instructions, obey the rules of the game, and get regular medical evaluation.

No student will be allowed to participate in practice or games until this form is signed and dated by both the student and parent/guardian.

ACKNOWLEDGEMENT OF WARNING BY STUDENT

I, _____, hereby acknowledge that I understand the above "STATEMENT OF RISKS". If I want more information, I will personally contact the coach. I realize that by participating in the sport(s) during the current school year, I am exposing myself to the risk of serious injury, including but not limited to, the risk of sprains, fractures and ligament and/or cartilage damage which could result in temporary or permanent, partial, or complete impairment in the use of my limbs, brain damage, paralysis or even death. Having been so cautioned and warned, it is still my desire to participate in the listed sport(s) and should I choose to participate in the listed sport(s), I hereby further acknowledge that I do so with full knowledge and understanding of the risk of serious injury to which I am exposing myself by participating in the listed sport(s).

Signature of Student

Date

ACKNOWLEDGEMENT OF WARNING BY PARENTS

We/I the parent(s) of _____ do hereby acknowledge that we/I understand the above "STATEMENT OF RISKS". If we/I want more information, we/I will personally contact the coach. We/I realize that our/my child named above may suffer serious injury, including but not limited to, sprains, fractures, brain damage, paralysis or even death by participating in the listed sport(s) and should we/I choose to allow our/my child to participate in the sport(s) during the current school year. Notwithstanding such warnings and with full knowledge and understanding of the risk of serious injury which may result to our/my child, named above, we/I give our/my consent to his/her participating in the below sport(s).

I acknowledge that my student athlete might be transported by a representative of the District in his/her own personal vehicle. I am aware that Portland Public Schools is not responsible for: 1) The District representative's insurance; 2) Injuries or property damage that may occur while my student is transported in a District representative's personal vehicle.

In other circumstances, a parent/guardian or fellow student might transport another student athlete. In these situations, the District is not responsible for organizing or approving these transportation plans.

Parent/Guardian Signature(s)

Date

INTENDED ATHLETIC PARTICIPATION

Name: _____

Year in School: (circle) FR SO JR SR
Intended Athletic Participation: Circle all that apply

Fall	Winter	Spring
Cross Country	Basketball	Baseball
Football	Wrestling	Softball
Soccer	Swimming	Track
Volleyball	Dance	Tennis
Cheerleading		Golf

HISTORY FORM

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

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

☐ Foods

☐ Stinging Insects

Explain "Yes" answers below. Circle questions you do not know the answers to.

GENERAL QUESTIONS		
1. When was the student's last complete physical or "checkup?" Date: Month/Year ____/____/____ (Ideally, every 12 months)	YES	NO
2. Has a doctor or other health professional ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical conditions? If so, please identify below.		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU		
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, or get tired more quickly than your friends or classmates during exercise?		
11. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		
12. Has any family member or relative died of heart problems or had an unexpected sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?		
13. Does anyone in your family have a pacemaker, an implanted defibrillator, or heart problems like hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia?		

BONE AND JOINT QUESTIONS	YES	NO
14. Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice, game or an event?		
15. Do you have a bone, muscle or joint problem that bothers you?		
MEDICAL QUESTIONS		
16. Do you cough, wheeze or have difficulty breathing during or after exercise?		
17. Have you ever used an inhaler or taken asthma medicine?		
18. Are you missing a kidney, an eye, a testicle (males), your spleen or any other organ?		
19. Do you have any rashes, pressure sores, or other skin problems such as herpes or MRSA skin infection?		
20. Have you ever had a head injury or concussion?		
21. Have you ever had numbness, tingling, or weakness, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or someone in your family have sickle cell trait or disease?		
24. Have you, or do you have any problems with your eyes or vision?		
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of food?		
28. Have you ever had an eating disorder?		
29. Do you have any concerns that you would like to discuss today?		
FEMALES ONLY		
30. Have you ever had a menstrual period?		
31. How old were you when you had your first menstrual period? _____		
32. 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 _____

ORS 336.479, Section 1 (3) "A school district shall require students who continue to participate in extracurricular sports in grades 7 through 12 to have a physical examination once every two years." Section 1(5) "Any physical examination required by this section shall be conducted by a (a) physician possessing an unrestricted license to practice medicine; (b) licensed naturopathic physician; (c) licensed physician assistant; (d) certified nurse practitioner; or a (e) licensed chiropractic physician who has clinical training and experience in detecting cardiopulmonary diseases and defects."

Form adapted from ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

PHYSICAL EXAMINATION FORM

Date of Exam: _____

Name: _____

Date of birth: _____

Sex: _____ Age: _____ Grade: _____ School: _____

Sport(s): _____

EXAMINATION		
Height:	Weight:	BMI:
BP: / (/)	Pulse:	Vision R 20/ L 20/ Corrected <input type="checkbox"/> YES <input type="checkbox"/> NO
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/ears/nose/throat		
Lymph nodes		
Heart •Murmurs (auscultation standing, supine, with and without Valsalva)		
Pulses		
Lungs		
Abdomen		
Skin		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		

☐ 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 provider may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians). This form is an exact duplicate of the current form required by the State Board of Education containing the same history questions and physical examination findings. I have also reviewed the "Suggested Exam Protocol".

Name of provider (print/type): _____

Date: _____

Address: _____

Phone: _____

Signature of provider: _____

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