2023 - 2024

>>Please Print in Ink<<

Woodburn High School Sport and Activity Information/Insurance/Consent Form

Sports		
Fall	Winter	Spring
FB	BBSKT	BSBL
GSOC	GBSKT	SFTBL
BSOC	WRSL	BTEN
VB	DANCE	GTEN
XC	CHEER	TRACK
DANCE		GOLF
CHEER		

Please Circle All That Apply

Instructions: Please complete all sections of this form, both front and back. DO NOT leave any spaces blank. Important Notes: Every student athlete must have medical insurance, and state law requires that all students have a valid physical examination at least once every two years. WHS will accept physical exams performed in the previous school year, provided the exam is recorded in the state-mandated format. No student will be allowed to participate, play, or practice in any way until complete paperwork has been submitted and processed.

Personal Information

Name: _____ Date of Birth: _____ Grade: _____

Last First MI

Address: _____

Street, Apartment, or PO Box # City, State, Zip

Home Telephone #: _____ Alternate Telephone #: _____

Parent/Primary Emergency Contact

Name : _____ Contact Telephone #: _____

Secondary Emergency Contact

Name : _____ Contact Telephone #: _____

Insurance Information

Students participating in athletics, activities, cheer squad and dance team must have appropriate insurance coverage. Please indicate your coverage below. Coverage must be maintained throughout the time of participation in Woodburn athletics/activities.

☐ School Insurance (Myers Stevens Toohey) _____
Administrator Initial/Date

☐ Migrant 1-M Program _____
Administrator Initial/Date

☐ Personal Insurance_____ _____
Company Name Policy Number

Consent for Participation/Helmet Warning

1. By signing below, the parent and student acknowledge the following statements and warnings:
2. I permit this student to participate in Woodburn High School (WHS) activities and contests.
3. **We (parent/guardian and student) have read and understand the WHS Athletic/Activities Academic and Behavioral Policy, and understand the consequences associated with violation of those rules.**
4. I permit WHS to transport this student to any activity/event in which he/she is participating as a team member.
5. I understand that a risk of injury is associated with participation in activities and contests.
6. I authorize WHS personnel to secure appropriate medical treatment for this student as necessary.
7. I authorize the release of this student's medical records and information regarding injuries or illnesses that are sustained while participating, or that may affect participation, in athletics and/or activities at WHS. I understand that the information released will be used only to ensure safe participation in interscholastic athletics, activities, or PE classes, ensure safe rehabilitation of injury in accordance with the physician's wishes, and otherwise facilitate appropriate health care as is conditionally necessary. This authorization is in effect for a period of one calendar year from the date signed below.
8. I recognize that WHS uses photo and video images of event in publicity materials such as the school website, newspaper, and newsletters and I hereby grant permission for images of my child to be taken and used for such purposes.
9. **(For football) HELMET WARNING: NO HELMET CAN PREVENT ALL HEAD AND NECK INJURIES. DO NOT USE THE HELMET TO HIT OR STRIKE AN OPPONENT. SUCH ACTIONS VIOLATE THE RULES OF PLAY, AS WELL AS SUBSTANTIALLY INCREASE THE CHANCE OF INCURRING A CONCUSSION OR OTHER SERIOUS HEAD OR NECK INJURY. THESE INJURIES COULD INCLUDE PERMANENT PARALYSIS AND EVEN DEATH.**
   CONCUSSION WARNING: BECOME FAMILIAR WITH THE SIGNS AND SYMPTOMS OF CONCUSSIONS, WHICH CAN INCLUDE HEADACHE, NAUSEA, CONFUSION, DIZZINESS AND MEMORY DIFFICULTIES, AND ENCOURAGE ALL ATHLETES TO REPORT SYMPTOMS. IF A CONCUSSION HAS BEEN DIAGNOSED, DO NOT RETURN TO PLAY UNTIL CLEARED BY MEDICALLY TRAINED EXPERTS FOLLOWING PUBLISHED RETURN-TO-PLAY GUIDELINES. (NOCSAE, 2010)
10. I understand that I may revoke any or all of the above authorizations at any time by doing so in writing to WHS. I also understand that the above authorizations are a requirement of participation and that revocation will result in removal of this student from the activity.
11. **I understand that signing below declares all information to be truthful and that insurance coverage is current and will be maintained during the term of participation during the school/athletics year.**
12. *Athlete*: **I have read, understand and will abide by the rules and expectations of the WHS Athletic/Activities Academic and Behavioral Policy.**
    Parent: **I have read, understand the rules and expectations of the WHS Athletic/Activities Academic and Behavioral Policy and give my son/daughter permission to participate in Woodburn High Campus athletics and activities.**

Parent/Guardian Signature: _____ Date: _____

Student Signature: _____ Date: _____

Medical History (complete every year)

Name: _____ **Birthdate:** _____

(YES)	(NO)	(Don't Know)	
			1. Has anyone in the athlete's family died suddenly before the age of 50 years?
			2. Has the athlete ever passed out during exercise or stopped exercising because of dizziness or chest pain?
			3. Does the athlete have asthma (wheezing), hay fever, other allergies, or carry an EPI pen?
			4. Is the athlete allergic to any medications or bee stings?
			5. Has the athlete ever broken a bone, had to wear a cast, or had an injury to any joint?
			6. Has the athlete ever had a head injury or concussion?
			7. Has the athlete ever had a hit or blow to the head that caused confusion, memory problems, or prolonged headache?
			8. Has the athlete ever suffered a heat-related illness (heat stroke)?
			9. Does the athlete have a chronic illness or see a physician regularly for any particular problem?
			10. Does the athlete take any prescribed medicine, herbs or nutritional supplements?
			11. Does the athlete have only one of any paired organ (eyes, kidneys, testicles, ovaries, etc.)?
			12. Has the athlete ever had prior limitation from sports participation?
			13. Has the athlete had any episodes of shortness of breath, palpitations, history of rheumatic fever or tiring easily?
			14. Has the athlete ever been diagnosed with a heart murmur or heart condition or hypertension?
			15. Is there a history of young people in the athlete's family who have had congenital or other heart disease: cardiomyopathy, abnormal heart rhythms, long QT or Marfan's syndrome? (You may write "I don't understand these terms" and initial this item, if appropriate.)
			16. Has the athlete ever been hospitalized overnight or had surgery?
			17. Does the athlete lose weight regularly to meet the requirements for your sport?
			18. Does the athlete have anything he or she wants to discuss with the physician?
			19. Does the athlete cough, wheeze, or have trouble breathing during or after activity?
			20. Are you unhappy with your weight?

21. FEMALES ONLY:
    - When was your first menstrual period? _____
    - When was your most recent menstrual period? _____
    - What was the longest time between menstrual periods in the last year? _____

Parent/Guardian's Statement: I have reviewed and answered the questions above to the best of my ability. I and my child understand and accept that there are risks of serious injury and death in any sport, including the one(s) in which my child has chosen to participate. I hereby give permission for my child to participate in sports & activities. I hereby authorize emergency medical treatment and/or transportation to a medical facility for any injury or illness deemed urgently necessary by a registered athletic trainer, coach, or medical practitioner. I understand that this sports pre-participation physical examination is not designed nor intended to substitute for any recommended regular comprehensive health assessment. I hereby authorize release of these examination results to my child's school.

***Signed:** _____ **Date:** _____

Parent/Guardian

*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."*

Physical Exam Section – To be completed by medical professional

HEIGHT: _____ WEIGHT: _____ % BODY FAT (optional):_____ PULSE: _____ BP: ___/___ ___ ____/____ ____/____

VISION: R 20/_____ L 20/_____ CORRECTED: Y N PUPILS: EQUAL_____ UNEQUAL_____

MEDICAL	NORMAL	ABNMORMAL FINDINGS	INITIAL*
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart: -Pericardial Activity			
-1st & 2nd heart sounds			
-Murmurs			
Pulses: brachial/femoral			
Lungs			
Abdomen			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Lower Leg/Ankle			
Foot			

*Station-based examination only

CLEARANCE

_____ **Cleared**

_____ **Cleared after completing evaluation / rehabilitation for:**

_____ **Not cleared for: Reason:** _____

Recommendations: _____

_____

_____

Name of Medical Provider: _____ **Date:** _____

Address: _____ **Phone**: (_____) _____

Signature of Medical Provider: _____

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