Norfolk Christian Athletic Participation Physical Form

Athlete's Name (First, Middle, Last): _____ Sport(s): _____

Year in School: _____ Date of Birth: _____

Home Address: _____

City/State/Zip Code: _____

Student Signature: _____ Date: _____

I give permission for _____ (name of child) to participate in athletics at Norfolk Christian School and I am aware that with the participation in sports comes the risk of injury to my child. 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, various handouts, or some other means. He/she is insured by our family policy with:

Name of Medical Insurance Company: _____

Policy Number: _____ Name of Policy Holder: _____

Primary Care Physician: _____

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 to participate in the sport and travel with the team.

On behalf of my son/daughter, I hereby authorize the athletic training staff of Norfolk Christian, as well as physicians and other health care providers, to render first aid, urgent or emergent care, and evaluation and medical treatment/rehabilitation to my son/daughter in connection with any athletic injury/illness, including, but not limited to arranging for transport to and treatment by a hospital or local health care provider.

On behalf of my son/daughter, I hereby authorize the athletic training staff of Norfolk Christian and/or physicians to perform Pre-Participatory Physical Examination prior to each year of athletic activity, including all associated testing and follow-up care.

_____ _____

Parent/Guardian Signature Date

_____

Parent Name Printed

Emergency Permission Form

Student's Name: _____ Grade: _____ Age: _____ Date of Birth: _____

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

_____

_____

Please list any allergies to medications, foods, etc. _____

_____

Is the student-athlete currently prescribed an inhaler or Epi-Pen? _____ List emergency medication: _____

Is the student-athlete presently taking any other medication? _____ If so, what type? _____

Does the student-athlete wear contact lenses? _____

Emergency Authorization: In the event that I cannot be reached in an emergency, I hereby give permission to physicians selected by the athletic training staff of Norfolk Christian to hospitalize, secure proper treatment for and to order injection and /or anesthesia and/or surgery for the person named above.

Daytime phone number (BEST number to reach you at in case of emergency): _____

Evening phone number (BEST number to reach you at in case of emergency): _____

Cell phone (If different from either number listed above): _____

I certify that all of the above information is correct:

_____ _____

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.

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

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

>>

>>

>>

>>

>>

>>

>>

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 ONLY FOR THE FOLLOWING SPORTS:**_____

Reason:_____

☐ **NOT MEDICALLY ELIGIBLE PENDING FURTHER EVALUATION OF:** _____

☐ **NOT 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 licensed to practice in the United States will be accepted.

Rule 28B-1 (3) Physical Examination Rule/Transfer Student (10-90)- When an out-of-state student who has received a current physical examination elsewhere transfers to Virginia and attaches proof of that physical examination to the League form #2, the student is in compliance with physical examination requirements.