

ATHLETICS ACTIVITY CARD- Weaverville Elementary School

My child _____ has my permission to participate in Weaverville Elementary School Athletic Programs and trips for the season. My child is physically able to participate in the Weaverville Elementary School Athletic Programs. To the best of my knowledge, he/she does not have any physical disability that would endanger his or her physical well being while participating in the athletic program. I GIVE MY CONSENT FOR MY CHILD TO PARTICIPATE IN ATHLETICS.

Parent/Guardian Signature _____

Date _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

In the event that my child becomes ill or sustains an injury while at school or during a school-sponsored function (field trip, etc.), permission is hereby given for the administration of first aid for his/her relief. If, in the opinion of the school officials or trip leaders, emergency medical or dental treatment is required, my consent is given to perform such procedures that the existing emergency requires for the relief of pain and to preserve his/her life and health. I understand that I am ultimately responsible for any expenses incurred regarding medical or dental treatment and that the Trinity Alps Unified School District ***DOES NOT PROVIDE*** medical insurance coverage for students that are injured at school or during a school activity, such as athletics.

Signature of Father/Guardian _____

Date _____

Father's Home Phone Number _____

Father's Work Phone Number _____

Signature of Mother/Guardian _____

Date _____

Mother's Home Phone Number _____

Mother's Work Phone Number _____

EMERGENCY INFORMATION: (Someone to contact when your child is ill or hurt and parent or guardian cannot be reached.)

Name: _____

Phone: _____

Doctor: _____

Phone: _____

Health Plan/Insurance (i.e. Blue Cross): _____

ID#: _____

Group #: _____

Medications: _____

Allergies: _____

Health Problems: _____

*******Beginning in the 2010-11 school year all Weaverville Elementary School students participating in athletics must have a physical examination prior to athletic participation (including tryouts & practices) and medical insurance coverage must be provided or purchased for students.**

ATHLETIC ACCIDENT INSURANCE INFORMATION — Weaverville Elementary School

The Trinity Alps Unified School District **DOES NOT PROVIDE** medical insurance coverage for students that are injured at school or during a school activity, such as athletics. California Education Code does require the District to provide information about insurance companies that offer adequate student-accident medical insurance. Myer-Stevens Insurance Company does offer student insurance coverage at a reasonable cost. Information about this company is available at the school office. Parents are responsible for the necessary accident insurance for their child. Parents may already have good insurance that is being provided by their employer or family purchased insurance. If there is no insurance coverage for the student, it **MUST** be purchased if the child wishes to try-out/participate in the school's athletic program and/or extra-curricular activities.

As a parent/guardian I already have adequate medical-accident insurance for my child,

_____ Birth date ____/____/____

All information below must be provided.

Insurance Company Name: _____

Policy Number: _____ Group Number: _____

Parent/Guardian Signature: _____ Date: ____/____/____

---- OR ----

As a parent I do not have accident insurance, but have purchased for my child,

_____. Birth date ____/____/____

I have sent a check to purchase the insurance on ____/____/____ (date).

Insurance Company Name: _____

I have purchased the following type of insurance:

____ Football Only ____ School Time ____ Full Time

Parent/Guardian Signature: _____ Date: ____/____/____

PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- 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?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female	
BP / / (/)	Pulse	Vision R 20/	L 20/ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) 			
Eyes/ears/nose/throat <ul style="list-style-type: none"> Pupils equal Hearing 			
Lymph nodes			
Heart* <ul style="list-style-type: none"> Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI) 			
Pulses <ul style="list-style-type: none"> Simultaneous femoral and radial pulses 			
Lungs			
Abdomen			
Genitourinary (males only) [†]			
Skin <ul style="list-style-type: none"> HSV, lesions suggestive of MRSA, tinea corporis 			
Neurologic [‡]			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional <ul style="list-style-type: none"> Duck-walk, single leg hop 			

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[†]Consider GU exam if in private setting. Having third party present is recommended.
[‡]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