AYLETT COUNTRY DAY SCHOOL
P.O. BOX 70, MILLERS TAVERN, VIRGINIA 23115
Athletic Participation/Parental Consent/Physical Examination Form
PLEASE PRINT CLEARLY

Separate signed form is required for each school year. Grade and School Year _____

Male ___ Female ____ Date of Birth _____

Name _____
(Last) (First) (Middle Initial)

Home Address _____

Home Address of Parents _____

ACKNOWLEDGEMENT OF RISK AND INSURANCE STATEMENT
(To be completed and signed by parent/guardian)

I give permission for _____ (name of child) to participate in athletic events, physical education and the physical evaluation for the participation. 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, written 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: _____

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.

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 participating in athletics/activities for his/her school during the school year covered by this form. I further consent to allow said physician(s) or heath 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.

EMERGENCY PERMISSION FORM
(To be completed and signed by parent/guardian)

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, etc. __

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

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

Does student wear contact lenses? _____ Date of last 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 Aylett Country Day School to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for the person named above.

Emergency Contact Numbers: Daytime: _____ Evening: Cell phone

►►Signature of parent or guardian _____ _____ Date _____

Relationship to student _____ _____

_____

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

AYLETT COUNTRY DAY SCHOOL
MEDICAL HISTORY

(This form must be completed and signed, prior to the physical examination, for review by examining practitioner.)

GENERAL MEDICAL HISTORY	Yes	No	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐	26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
2. Do you currently have an ongoing medical condition? If so, Please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections ☐ Other:	☐	☐	27. Do you have asthma or use asthma medicine (inhaler, nebulizer)	☐	☐
3. Have you ever spent the night in the hospital?	☐	☐	28. Were you born without or are you missing a kidney, an eye, a testicle, spleen or any other organ?	☐	☐
4. Have you ever had surgery?	☐	☐	29. Do you have groin pain or a painful bulge or hernia in the groin area?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**	30. Have you had mononucleosis (mono) within the last month?	☐	☐
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?	☐	☐	31. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
6. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐	32. Have you ever had a herpes or MRSA skin infection?	☐	☐
7. Does your heart race or skip beats during exercise?	☐	☐	33. Are you currently taking any medication on daily basis?*	☐	☐
8. Has a doctor ever told you that you have (check all that apply): ☐High Blood Pressure ☐A heart murmur ☐High cholesterol ☐A heart infection ☐Kawasaki disease ☐Other:	☐	☐	34. Have you ever had a head injury or concussion? If so, date of last injury: _____	☐	☐
9. Has a doctor ever ordered a test for your heart? (For ex: ECG/EKG, echocardiogram)	☐	☐	35. Have you ever had a numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
10. Do you get lightheaded or feel more short of breath than expected during exercise?	☐	☐	36. Do you have headaches with exercise?	☐	☐
11. Have you ever had an unexplained seizure?	☐	☐	37. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**	38. When exercising in heat, do you have severe muscle cramps or become ill?	☐	☐
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)?	☐	☐	39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
13. Does anyone in your family have a heart problem?	☐	☐	40. Have you had any other blood disorders?	☐	☐
14. Does anyone in your family have a pacemaker or implanted defibrillator?	☐	☐	41. Have you had any problems with your eyes or vision?	☐	☐
15. Does anyone in your family have Marfan syndrome, cardiomyopathy, or Long Q-T?	☐	☐	42. Do you wear glasses or contact lenses?	☐	☐
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	☐	☐	43. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
BONE AND JOINT QUESTIONS	**Yes**	**No**	44. Do you worry about your weight?	☐	☐
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?	☐	☐	45. Are you trying to or has any professional recommended that you try to gain or lose weight?	☐	☐
18. Have you had any broken or fractured bones or dislocated joints?	☐	☐	46. Do you limit or carefully control what you eat?	☐	☐
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?	☐	☐	47. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
20. Have you ever had an x-ray of your neck for atlanto-axial instability? OR Have you ever been told that you have that disorder or any neck/spine problem?	☐	☐	48. When is the date of your last Tdap or Td (tetanus) immunization? (Circle Type) Date: _____	☐	☐
21. Have you ever had a stress fracture of the bone?	☐	☐	**FEMALES ONLY**	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐	49. Have you ever had a menstrual period?	☐	☐
23. Do you currently have a bone, muscle, or joint injury that bothers you?	☐	☐	50 Age when you had your first menstrual period? _____	☐	☐
24. Do any of your joints become painful, swollen, feel warm, or look red?	☐	☐	51. How many periods have you had in the last 12 months? _____	☐	☐
25. Do you have a history of juvenile arthritis or connective tissue disease?	☐	☐			

EXPLAIN "YES" ANSWERS BELOW:

#____ » _____

#____ » _____

#____ » _____

#____ » _____

*List medications and nutritional supplements you are currently taking here:

►►Parent/Guardian Signature: _____ Date: _____

AYLETT COUNTRY DAY SCHOOL
PHYSICAL EXAMINATION
(Physical examination is required each school year)

NAME_____ Date of Birth _____

EXAMINATION			
Height:	Weight:	Male ☐	Female ☐
BP : /	Pulse:	Vision: R 20/ L 20/	Corrected Yes No

MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance		
Eyes/ears/nose/throat		
Lymph nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin		
Neurologic		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional		
Medical Practitioner to School Staff (please indicate any instructions or recommendations here)		
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.

☐ **CLEARED WITHOUT RESTRICTIONS**

☐ **CLEARED WITH FOLLOWING NOTATION:** _____

☐ Cleared **AFTER** documented further evaluation or treatment for: _____

☐ Cleared for l**imited participation** (check and explain "reason" for all that apply): *"Limited Until Date" when appropriate*

☐ Not cleared for (specific sports)_____ Until Date: _____

Reason(s): _____

☐ **NOT CLEARED FOR PARTICIPATION**

Reason(s): _____

I have examined the above-named student and completed the preparticipation physical evaluation.

Physician Signature: _____ + (MD, DO, LNP, PA) Circle one Date _____

Address: _____ Phone Number _____

+ Only signatures of Doctor of Medicine, Doctor of Osteopathic Medicine, Nurse Practitioner or Physician's Assistant licensed to practice in the United States will be accepted