

GAINESVILLE ATHLETIC REGISTRATION

PLEASE PRINT ALL INFORMATION:

Name of Student: _____ **Grade** _____

Name(s) of Parent or Guardian: _____

Home Phone Number: _____ **Emergency Number** _____

PARENTAL CONSENT FOR ATHLETIC PARTICIPATION

WARNING: Although participation in supervised interscholastic athletics may be one of the least hazardous in which students will engage in or out of school, by its nature participation in interscholastic athletics includes a risk of injury which may range in severity from minor to long term catastrophic. Although serious injuries are not common in supervised school athletic programs, it is possible only to minimize, not eliminate, the risk.

Participants have the responsibility to help reduce the risk of injury. **Players must obey all safety rules, report all physical problems to their coaches, follow a proper conditioning program, and inspect their equipment daily.**

By signing this permission form, you acknowledge that you have read and understand this warning.

Parents or students who do not wish to accept the risks described in this warning should not sign this permission form.

I, (we) hereby give consent for _____ to:

- (1) Compete in interscholastic athletics as a part of the Gainesville Athletic Departments, **except those CROSSED OUT** below:

Baseball	Cross Country	Soccer	Track & Field	Lacrosse
Basketball	Football	Softball	Volleyball	
Cheerleading	Golf	Tennis	Wrestling	

- (2) To accompany any school team of which the student is a member on any of its local or out-of-town trips;
- (3) And, I hereby verify that the information on both sides of this form is correct and understand that any false information may result in my son/daughter being declared ineligible.

This acknowledgement of risk and consent to allow participation shall remain in effect until revoked in writing.

SIGNATURE(S) OF PARENT(S) OR GUARDIAN(S): _____

DATE: _____

SIGNATURE OF STUDENT-ATHLETE: _____

DATE: _____

**PREPARTICIPATION PHYSICAL EVALUATION
THE ATHLETE WITH SPECIAL NEEDS:
SUPPLEMENTAL HISTORY FORM**

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

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 _____

PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name _____ Sex M F Age _____ Date of birth _____

- 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

EMERGENCY INFORMATION

Allergies _____

Other information _____

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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 • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperflexity, myopia, MVP, aortic insufficiency)			
Eyes/ears/nose/throat • Pupils equal • Hearing			
Lymph nodes			
Heart* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only) [†]			
Skin • 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 • 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.

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- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____
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- Reason _____

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