ATHLETIC REGISTRATION & PHYSICAL FORM
SEATTLE SCHOOL DISTRICT ATHLETIC DEPARTMENT

Id Number

SECTION I: INFORMATION

☐ F ☐ M Birth Date Grade

Student-Athlete Name: _____
Last First Middle Initial

Home Address _____ Home Phone _____

Mother's Name _____ Home Phone _____ Bus. Phone _____

Father's Name _____ Home Phone _____ Bus. Phone _____

Family Doctor _____ Doctor's Phone _____

Preferred Hospital _____ Phone _____

Medications in use _____ Medicine Allergic to _____

School attended last year: _____
School Name City/State

Private School Student: ☐ yes ☐ no If yes, school name: _____

SECTION II: MEDICAL EMERGENCY AUTHORIZATION

Name of Student Athlete _____ Athletic School _____

I hereby grant permission to the Athletic Trainer Sports Service Provider and Team Physicians, or other physicians designated by the above named school and Parent/Guardian to provide my child with any medical care or surgical care that they deem reasonably necessary to my child's health and well being as a result of injuries or other medical conditions occurring as the result of or during athletic activities.

I further authorize the Athletic Trainer Sports Service Provider's who are under the direction and guidance of a physician to provide my child with any preventive, first-aid, rehabilitative or emergency treatment they deem reasonably necessary to my child's health and well being as a result of injuries or other medical conditions occurring as the result of/or during athletic activities.

If reasonably necessary to provide the care described in the preceding two paragraphs, I grant permission to the Athletic Trainer Sports Service Provider and/or school officials to seek necessary treatment at a hospital or health care center. _____

Person to call in case of injury _____ Relationship _____ Phone _____

→ _____ _____
Parent/Guardian Signature Date

SECTION III: SPORT INJURY RISK PARENT CONSENT

Student may participate in a maximum of three (3) sports, one per sport season. Please indicate your choice(s) by placing a check mark in the box next to the selected sport(s). ***Please see attached Sport Risk/Injury Parent Consent forms for approval of chosen sports for your son/daughter*:**

Fall: ☐ X Country ☐ Football ☐ Golf (Co-Ed) ☐ G/Soccer* ☐ G/Swimming
☐ Volleyball ☐ Middle School Ultimate Frisbee

Winter: ☐ Basketball* ☐ Gymnastics ☐ B/Swimming ☐ Wrestling

Spring: ☐ Baseball ☐ Track* ☐ B/Soccer* ☐ Softball ☐ Tennis
☐ Middle School Volleyball

Cheer Squad ☐ Yes ☐ No Additional Sport/Activity _____

** High School & Middle School Sport in same season*

SECTION IV: MANDATORY ATHLETIC INSURANCE

I understand that my son/daughter may not participate in boys' or girls' after-school athletics unless he/she is covered by the approved Seattle School District Athletic Insurance Program or by an equivalent plan which provides benefits for loss due to a covered injury with a minimum benefit of $25,000 for each injury including the following minimum provisions:

- o Surgery..... 50% of usual and customary charges/$12,000 maximum
- o Physician Visits..... $40 per day for first visit and $25 for following visits
- o Emergency Room..... 60%
- o X-Rays..... 60% or up to $500
- o +MRI and CAT scan..... +80% or up to $500
- o Dental..... 100% of usual and customary charges/$12,000 (all teeth) – separate plan with one limit

Please check one of the options and then sign below

Option 1: ☐ My son/daughter is currently enrolled in the approved Seattle School District Student Accident and Health Insurance Program.

OR

Option 2: ☐ My son/daughter is covered by a plan that is equivalent or better than the above requirements and I will continue to keep it in force throughout the sports season; therefore, I do not wish to enroll my son/daughter in the Seattle School District Athletic Insurance Program (high school) or the Seattle School District regular school insurance program (middle school).

Name of Company Providing Coverage _____ Policy Number or Employee Name _____

→ _____ Parent/Guardian Signature _____ Date

SECTION V: PHYSICAL EXAMINATION

Washington Interscholastic Activities Association (WIAA) regulation 18.13.0 requires that prior to the first practice for participation in interscholastic athletics a student shall undergo a thorough medical examination and be approved for middle level and/or high school interscholastic athletic competition by a medical authority licensed to perform a physical examination. This physical examination must include, but is not necessarily limited to:

- o Documentation of a detailed review of the student's medical history with special attention to presence or absence of cardiovascular/pulmonary risks and/or previous significant injury and rehabilitation there from.
- o Documentation of satisfactory examination of the cardiopulmonary system.
- o Documentation of satisfactory sport-specific orthopedic screening examination.
- o A written statement by the examiner as to the fitness of the student to undertake the proposed athletic participation, together with suggestions for activity modification if necessary.

WIAA regulation 17.11.6 states that for each subsequent twenty-four month period the student shall furnish a statement or physical examination form signed by a medical authority licensed to perform a physical examination that provides clearance for continued athletic participation.

PRE-PARTICIPATION HISTORY AND PHYSICAL EXAMINATION

(Pages 3 and 4 to be completed by a medical authority licensed to give physical examinations.)

Name _____ Birth Date _____ Exam Date _____

Address _____ City, WA _____ Zip _____

Phone _____ Sport _____ Grade Level @ Exam _____

HISTORY

		Yes	No	
1.	a.	☐	☐	Have you had any illness/injury recently, or do you have an illness/injury now?
	b.	☐	☐	Have you had a medical problem, illness or injury since your last exam?
	c.	☐	☐	Do you have any chronic or recurrent illness?
	d.	☐	☐	Have you ever had any illness lasting more than a week?
	e.	☐	☐	Have you ever been hospitalized overnight?
	f.	☐	☐	Have you had any surgery other than tonsillectomy?
	g.	☐	☐	Have you ever had any injuries requiring treatment by a physician?
	h.	☐	☐	Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc.)?
2.		☐	☐	Are you presently taking ANY medications (including birth control pill, vitamin, aspirin, etc.)?
3.		☐	☐	Do you have ANY allergies (medicines, bees, foods, or other factors)?
4.	a.	☐	☐	Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?
	b.	☐	☐	Do you tire more easily or quickly than your friends during exercise?
	c.	☐	☐	Have you ever had any problem with your blood pressure or your heart?
	d.	☐	☐	Have any close relatives had heart problems, heart attack or sudden death before they were age 50?
5.		☐	☐	Do you have any skin problems (acne, itching, rashes, etc.)?
6.	a.	☐	☐	Have you ever had fainting, convulsions, seizures or severe dizziness?
	b.	☐	☐	Do you have frequent severe headaches?
	c.	☐	☐	Have you ever had a “stinger” or “burner” or “pinched nerve”?
	d.	☐	☐	Have you ever been “knocked out” or “passed out”?
	e.	☐	☐	Have you ever had a neck or head injury?
7.		☐	☐	Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems?
8.		☐	☐	Have you had asthma, or trouble breathing, or cough during or after exercise?
9.	a.	☐	☐	Do you wear eyeglasses, contact lenses or protective eye wear?
	b.	☐	☐	Have you had any problem with your eyes or vision?
10.		☐	☐	Do you wear any dental appliance such as braces, bridge, plate, retainer?
11.	a.	☐	☐	Have you ever had a knee injury?
	b.	☐	☐	Have you ever had an ankle injury?
	c.	☐	☐	Have you ever injured any other joint (shoulder, wrist, fingers, etc.)?
	d.	☐	☐	Have you ever had a broken bone (fracture)?
	e.	☐	☐	Have you ever had a cast, splint, or had to use crutches?
	f.	☐	☐	Must you use special equipment for competition (pads, braces, neck roll, etc.)?
12.		☐	☐	Has it been more than 5 years since your last tetanus booster shot?
13.		☐	☐	Are you worried about your weight?
14.		☐	☐	FEMALES: Have you any menstrual problems?
15.		☐	☐	Have you any medical concerns about participating in your sport?

Examiner’s comments on all “YES” answers (refer to question number):

PHYSICAL EXAMINATION

Box Optional

Name _____

Age _____ Pulse _____

Height _____ Blood Pressure _____

Weight _____ Visual Acuity Left 20/ _____

Right 20/ _____

Urinalysis:

Body Fat%:

HCT:

EST VO2 Max:

Audiometry:

Normal			Abnormal *(please explain)*
☐	1.	Head	☐
☐	2.	Eyes (pupils), ENT	☐
☐	3.	Teeth	☐
☐	4.	Chest	☐
☐	5.	Lungs	☐
☐	6.	Heart	☐
☐	7.	Abdomen	☐
☐	8.	Genitalia	☐
☐	9.	Neurological	☐
☐	10.	Skin	☐
☐	11.	Physical Maturity	☐
☐	12.	Spine, Back	☐
☐	13.	Shoulders, Upper extremities	☐
☐	14.	Lower extremities	☐

Assessment: ☐ Full Participation

☐ Limited participation *(describe limitations, restrictions)*

☐ Participation contraindicated *(list reasons)*

Recommendations (*equipment, taping, rehabilitation, etc.)*

Date _____ Examiner's signature _____

Examiner's phone ( ) Print Examiner's Name: