

# FCPS MIDDLE SCHOOL SPORTS ATHLETIC PARTICIPATION/PARENTAL CONSENT/PHYSICAL EXAMINATION FORM

Separate signed form is required for each school year MAY 1 of the current year through JUNE 30 of the succeeding year.

For school year \_\_\_\_\_

### PART I- ATHLETIC PARTICIPATION (To be filled in and signed by the student)

Male \_\_\_\_\_  
Female \_\_\_\_\_

**PRINT CLEARLY**

Name \_\_\_\_\_ Student ID# \_\_\_\_\_  
(Last) (First) (Middle Initial)

Home Address \_\_\_\_\_

City/Zip Code \_\_\_\_\_

Home Address of Parents \_\_\_\_\_

City/Zip Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

### INDIVIDUALIZED ELIGIBILITY RULES

To be eligible to represent your school in any FCPS middle school interscholastic athletic contest, you:

- Must be a regular bona fide student in good standing of the school you represent.
- Must be currently enrolled in not fewer than five subjects, or their equivalent.
- As determined by the principal, eligible to participate in the middle school after-school program and middle school athletic program.
- Must have submitted to your principal before any kind of participation, including tryouts or practice as a member of any school athletic team, an Athletic Participation/Parent Consent/Physical Examination Form, completely filled in and properly signed attesting that you have been examined during this school year and found to be physically fit for competition and that your parents' consent to your participation.

Eligibility to participate in interscholastic athletics is a privilege you earn by meeting not only the above-listed minimum standards, but also all other standards set by FCPS and your school. If you have any question regarding your eligibility or are in doubt about the effect an activity might have on your eligibility, **check with your principal for interpretations.** Meeting the intent and spirit of these standards will prevent you, your team, school, and community from being penalized. Additionally, I give my consent and approval for my picture and name to be printed in any school or FCPS athletic program, publication or video.

**EACH SCHOOL MAY REQUIRE ADDITIONAL STANDARDS TO THOSE LISTED ABOVE.**

→Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PROVIDING FALSE INFORMATION WILL RESULT IN INELIGIBILITY FOR ONE YEAR.**

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)**

GENERAL MEDICAL HISTORY						YES		NO		MEDICAL QUESTIONS CONTINUED				YES		NO							
1. Do you have any concerns that you would like to discuss with your provider?						<input type="checkbox"/>	<input type="checkbox"/>	24. Have you had mononucleosis (mono) within the last month?				<input type="checkbox"/>	<input type="checkbox"/>	25. Are you missing a kidney, eye, testicle, spleen or other internal organ?				<input type="checkbox"/>	<input type="checkbox"/>				
2. Has a provider ever denied or restricted your participation in sports for any reason?						<input type="checkbox"/>	<input type="checkbox"/>	26. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?				<input type="checkbox"/>	<input type="checkbox"/>	27. Have you ever become ill while exercising in the heat?				<input type="checkbox"/>	<input type="checkbox"/>				
3. Do you have any ongoing medical conditions? If so, please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections <input type="checkbox"/> Other: _____						<input type="checkbox"/>	<input type="checkbox"/>	28. When exercising in the heat, do you have severe muscle cramps?				<input type="checkbox"/>	<input type="checkbox"/>	29. Do you have headaches with exercise?				<input type="checkbox"/>	<input type="checkbox"/>				
4. Are you currently taking any medications or supplements on a daily basis?						<input type="checkbox"/>	<input type="checkbox"/>	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?				<input type="checkbox"/>	<input type="checkbox"/>	31. Do you or does someone in your family have sickle cell trait or disease?				<input type="checkbox"/>	<input type="checkbox"/>				
5. Do you have allergies to any medications?						<input type="checkbox"/>	<input type="checkbox"/>	32. Have you had any other blood disorders?				<input type="checkbox"/>	<input type="checkbox"/>	33. Have you had a concussion or head injury that caused confusion, a prolonged headache or memory problems?				<input type="checkbox"/>	<input type="checkbox"/>				
6. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?						<input type="checkbox"/>	<input type="checkbox"/>	34. Have you had or do you have any problems with your eyes or vision?				<input type="checkbox"/>	<input type="checkbox"/>	35. Do you wear glasses or contacts?				<input type="checkbox"/>	<input type="checkbox"/>				
7. Have you ever spent the night in the hospital? If yes, why? _____						<input type="checkbox"/>	<input type="checkbox"/>	36. Do you wear protective eyewear like goggles or a face shield?				<input type="checkbox"/>	<input type="checkbox"/>	37. Do you worry about your weight?				<input type="checkbox"/>	<input type="checkbox"/>				
8. Have you ever had surgery?						<input type="checkbox"/>	<input type="checkbox"/>	38. Are you trying to or has anyone recommended that you gain or lose weight?				<input type="checkbox"/>	<input type="checkbox"/>	39. Do you limit or carefully control what you eat?				<input type="checkbox"/>	<input type="checkbox"/>				
HEART HEALTH QUESTIONS ABOUT YOU						YES		NO		40. Have you ever had an eating disorder?				<input type="checkbox"/>	<input type="checkbox"/>	41. Are you on a special diet or do you avoid certain types of foods or food groups?				<input type="checkbox"/>	<input type="checkbox"/>		
9. Have you ever passed out or nearly passed out DURING or AFTER exercise?						<input type="checkbox"/>	<input type="checkbox"/>	42. Allergies to food or stinging insects?				<input type="checkbox"/>	<input type="checkbox"/>	43. Have you ever had a COVID-19 diagnosis? Date: _____				<input type="checkbox"/>	<input type="checkbox"/>				
10. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?						<input type="checkbox"/>	<input type="checkbox"/>	44. What is the date of your last Tdap or Td (tetanus) immunization? (circle type) Date: _____				<input type="checkbox"/>	<input type="checkbox"/>	45. Have you ever had a menstrual period?				<input type="checkbox"/>	<input type="checkbox"/>				
11. Does your heart race, flutter in your chest or skip beats (irregular beats) during exercise?						<input type="checkbox"/>	<input type="checkbox"/>	46. Age when you had your first menstrual period: _____								47. Number of periods in the last 12 months: _____							
12. Has a doctor ever ordered a test for your heart? For example, electrocardiography or echocardiography.						<input type="checkbox"/>	<input type="checkbox"/>	48. When was your most recent menstrual period? _____															
13. Has a doctor ever told you that you have any heart problems, including: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki Disease <input type="checkbox"/> Other _____						<input type="checkbox"/>	<input type="checkbox"/>																
14. Do you get light-headed or feel shorter of breath than your friends during exercise?						<input type="checkbox"/>	<input type="checkbox"/>																
15. Have you ever had a seizure?						<input type="checkbox"/>	<input type="checkbox"/>																
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY						YES		NO															
16. Does anyone in your family have a heart problem?						<input type="checkbox"/>	<input type="checkbox"/>																
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)?						<input type="checkbox"/>	<input type="checkbox"/>																
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)?						<input type="checkbox"/>	<input type="checkbox"/>	# >>															
19. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?						<input type="checkbox"/>	<input type="checkbox"/>	# >>															
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?						<input type="checkbox"/>	<input type="checkbox"/>	# >>															
21. Do you currently have a bone, muscle or joint injury that bothers you?						<input type="checkbox"/>	<input type="checkbox"/>	# >>															
MEDICAL QUESTIONS						YES		NO															
22. Do you cough, wheeze or have difficulty breathing during or after exercise?						<input type="checkbox"/>	<input type="checkbox"/>																
23. Do you have asthma or use asthma medicine (inhaler, nebulizer)?						<input type="checkbox"/>	<input type="checkbox"/>																

→ 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	<input type="checkbox"/> Male	<input type="checkbox"/> Female
BP /	Resting pulse	Vision R 20/	L 20/
		Corrected	<input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Inhaler <input type="checkbox"/> Epinephrine <input type="checkbox"/> Glucagon <input type="checkbox"/> 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.**

NOTE: When an out-of-jurisdiction student who has received a current athletic physical examination elsewhere transfers to FCPS and attaches proof of that physical examination to this form, the student is in compliance with physical examination requirements.

**PART IV- ACKNOWLEDGEMENTS OF RISK AND INSURANCE STATEMENT**

(To be completed by parent/guardian)

I give permission for \_\_\_\_\_ (name of child/ward) to participate in any of the following sports that are NOT crossed out: cross country, track.

I have reviewed the individual eligibility rules and I am aware that with the participation in sports comes the risk of injury to my child/ward. 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 has student medical/accident insurance available through the school (yes\_\_ no\_\_); has athletic participation insurance coverage through the school (yes\_\_ no\_\_); 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/ward 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 participation in athletics/activities for his/her school during the school year covered by this form. I further consent to allow said physician(s) of health 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.

Additionally, I give my consent and approval for the above-named student's picture and name to be printed in any school or FCPS athletic program, publication, or video.

To access quality, low-cost comprehensive health insurance through FAMIS for your child, please contact Cover Virginia by going to [www.coverva.org](http://www.coverva.org) or calling 855-242-8282.

**PART V- EMERGENCY PERMISSION FORM\***

(To be completed and signed by the parent/guardian)

STUDENT'S NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_ AGE: \_\_\_\_\_ DOB: \_\_\_\_\_

MIDDLE SCHOOL: \_\_\_\_\_ CITY: \_\_\_\_\_

Please list and 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 CURRENT PRESCRIBED AN INHALER OR EPI-PEN? \_\_\_\_\_ LIST THE EMERGENCY MEDICATION: \_\_\_\_\_

IS THE STUDENT PRESENTLY TAKING ANY OTHER MEDICATION? \_\_\_\_\_ IF SO, WHAT? \_\_\_\_\_

DOES THE STUDENT WEAR CONTACT LENSES? \_\_\_\_\_ DATE OF LAST Tdap OR Td (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 \_\_\_\_\_ Middle School to hospitalize, secure proper treatment for and to order the injection and/or anesthesia and/or surgery for the person named above.

DAYTIME PHONE NUMBER (WHERE TO REACH YOU IN AN EMERGENCY): \_\_\_\_\_

EVENING TIME PHONE NUMBER (WHERE TO REACH YOU IN AN EMERGENCY): \_\_\_\_\_

CELL PHONE NUMBER: \_\_\_\_\_

→ 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.

→ I CERTIFY ALL OF THE ABOVE INFORMATION IS CORRECT: \_\_\_\_\_

Parent/Guardian signature

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