MADISON SCHOOLS
PREPARTICIPATION HEALTH EVALUATION

PERSONAL INFORMATION

Name of Student _____ Sex_____ **Grade Level 2015-16** _____ Age ____ Date of Birth _____

Street Address: _____City_____Zip_____Home Phone: _____

Father's Name: _____ Address if different: _____

Mother's Name : _____ Address if different: _____

Family Physician: _____ Office Phone: _____

In case of emergency, parents will be contacted first. Please list a non-parent contact:

Name _____ Relationship _____

Address _____ Phone (H) _____ (W) _____

STUDENT PARTICIPATION

**This application to participate in athletics is voluntary on my part and the information submitted is truthful to the best of my knowledge.

**I have never received money or negotiable certificates for merchandise in any amount, nor any emblematic award or merchandise worth more than twenty-five dollars ($25.00) for participating in athletic events, nor have I ever competed under an assumed name. After I have represented my high school in any sport, I will not compete in any outside athletic contest in this sport until after the high school season has been completed.

**I understand that I am expected to adhere firmly to all established athletic policies of my school district and the Michigan High School Athletic Association, such as those previously mentioned above as examples but which do not present all the policies to which I am subject. I consent to the disclosure to the MHSAA of information otherwise protected by FERPA and HIPPA for the purpose of determining eligibility for interscholastic athletics.

PARENT OR GUARDIAN CONSENT – INJURY WAIVER FORM

**I hereby give my consent for the above student to engage in interscholastic athletics and understand the possibility that serious injury may result from participating in athletic activities. He/she has my permission to accompany the team as a member on its out-of-town trips.

**I understand that my son or daughter will be expected to adhere firmly to all established athletic policies of the school district and the Michigan High School Athletic Association. I consent to the disclosure to the MHSAA of information otherwise protected by FERPA and HIPPA for the purpose of determining eligibility for interscholastic athletics.

**I agree to reimburse the Athletic Department for equipment/uniforms issued to my son/daughter should it not be returned.

**As the parent or guardian of _____, in case of accident or serious illness, I request the school to contact me at this/these number(s) _____

_____

**If I cannot be reached I give my authorization to my son/daughter's athletic coach to sign in lieu of me for any medical treatment that he/she feels is necessary. Our family physician is _____.

**We have our own insurance policy. Yes No Name of company _____.

I hereby state that, to the best of my knowledge, the above information is correct and agree to abide by all conditions stated above.

X_____ Date _____
Signature of Student

X_____ Date:_____
Signature of Parent or Guardian

****I understand that this entire form will be used for any emergency medical treatment my child might require.**
I also understand this entire form may be copied for use by the athletic trainer and/or coaches.
THIS FORM MUST BE ON FILE IN THE HIGH SCHOOL OFFICE BEFORE PRACTICING
WITH ANY ATHLETIC TEAM, PURSUANT TO MHSAA RULES

PHYSICAL EXAMINATION

Name ____ Date of Birth ______________

To be completed by athlete/parent prior to physical:

HISTORY	YES	NO	HISTORY	YES	NO	HISTORY	YES	NO
Have you ever had:			Have you ever had:			Do you now have:		
Fainting			Kidney Disease			Painful Joints		
Diphtheria			Tuberculosis			Backaches		
Scarlet Fever			Jaundice			Pounding of Heart		
Rheumatism			Sickle-Cell Anemia			Shortness of Breath		
Rupture						Frequent Urination		
Rheumatic Fever						Cough		
			Do you now have:					
Poliomyelitis			Blurred Vision			Nosebleeds		
Pneumonia			Headaches			Frequent Sore Throats		
Asthma			Fainting			Stomach Pains		
Diabetes			Convulsions					
Heart Disease			Blackouts					

*

To be completed by examining MD, DO, Physician's Assistant on day of physical:

Height _______________ Weight _______________ Pulse _________ Blood Pressure ____________

Vision: Left _____________ Right ______________ Glasses/Contacts ____________________

PHYSICAL EXAMINATION

To be completed by the examining MD, DO, Physician's Assistant or Nurse Practitioner.
(Categories may be added or deleted; check appropriate column.)

SYSTEM	NORMAL	ABN.	SYSTEM	NORMAL	ABN
Urinalysis			Chest		
Vision			Lungs		
Ears			Heart		
Nose			Abdomen		
Throat			Hernia		
Teeth-Cavities			Genitalia/Testicular Exam		
Orthopedic			Neurologic		
Thyroid			Muscular		

RECOMMENDATIONS: ____

____

I certify that I have examined the above student and recommend him/her as being able to compete in supervised athletic activities not crossed out below.

BASEBALL—BASKETBALL—BOWLING---COMPETITIVE CHEER—CROSS COUNTRY—FOOTBALL
GOLF—SOFTBALL—TRACK—VOLLEYBALL—WRESTLING

SIGNATURE OF
EXAMINER: X ____

CIRCLE ONE:
__ MD __ DO __ PA __ NP__________________

PRINTED NAME
OF EXAMINER:____________________________________

DATE:
____

A CURRENT YEAR PHYSICAL IS ONE GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR.