

## 2010-2011 MOUNT MADONNA SCHOOL SPORTS FORM

**This form must be completed for all students participating in after-school sports.**

Parents and students, please initial parts one and two on page 1. Complete all of page 2. Make a copy and submit to the School Office by June 1, 2010. Retain a copy of page 1 and give to your child's doctor to fill out during the Sports Physical Examination. Submit the Sports Physical Examination, filled out and signed by your physician, on/by the first day of school in September 2010.

**PLEASE PRINT CLEARLY**

### SPORTS PHYSICAL EXAM, INJURY WARNING, AND SUBSTANCE ABUSE POLICY

**\*\*All students playing after school sports require an annual physical\*\***

#### WARNING OF SERIOUS PHYSICAL INJURY

Participation in competitive athletics may result in severe injury, including paralysis or death. Changes in rules, improved conditioning programs, better medical coverage, and improvements in equipment have reduced these risks, but it is impossible to totally eliminate occurrences from athletics.

Players can reduce the chance of injury by obeying all safety rules in their sport, reporting physical problems to their coaches, following a proper conditioning program and inspection of their own equipment daily. Damaged equipment must be replaced immediately. Even if all these requirements are met, and even if the athlete is using excellent protective equipment, a serious accident may still occur. As a condition of participation in athletics at Mount Madonna School, we acknowledge that we have read and understand this warning statement.

Initials: Parent \_\_\_\_\_

Student \_\_\_\_\_

### ATHLETICS AND SUBSTANCE ABUSE POLICY

As a parent/guardian of this student, I recognize that my child must remain chemically free to participate fully in this activity. Therefore, I acknowledge the policies of Mount Madonna School, which prohibit the use of alcohol and drugs (except those legally prescribed) while under the jurisdiction of the school, for the term of this activity.

As a student-participant, I acknowledge the policies of Mount Madonna School regarding substance abuse. I realize that this policy prohibits my possession and use of alcohol and drugs (except those legally prescribed) while under the jurisdiction of the school, for the term of this activity.

Initials: Parent \_\_\_\_\_

Student \_\_\_\_\_

### SPORTS PHYSICAL EXAMINATION

Mount Madonna School requires all students participating in after school sports receive an annual physical. In addition, the Central Coast Section requires that all students participating in **high school** athletics receive a physical examination each year. Forms must be signed by a physician and returned to the Mount Madonna School office before the sports season begins.

#### PHYSICIAN'S STATEMENT AND PARENT CONSENT

Name \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_/\_\_\_\_ (\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_)

Exam	Normal	Abnormal Findings	Exam	Normal	Abnormal Findings
<b>Medical</b>			<b>Musc./Skel.</b>		
Eyes/ENT			Neck/Back		
Lymph Nodes			Shoulder/Arm		
Heart/Pulse			Elbow/Forearm		
Lungs			Wrist/Hand		
Abdomen			Hip/Thigh/Knee		
Skin			Leg/Ankle/Foot		

**Not cleared for (Reason/Recommendations):** \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Phone \_\_\_\_\_

Date \_\_\_\_\_

*Signature of Physician*

I hereby give my consent for the above-named to compete in sports and to go with a representative of the school on sports related trips. In case this student is injured, you are authorized to have him/her treated.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

## HEALTH HISTORY

**\*\*Required for all students involved in after-school sports\*\***

Explain "YES" answers at end.  
Circle answers you don't know the answer to.

- |   | YES / NO                 |                          |
|---|--------------------------|--------------------------|
| 1. Have you ever had a medical illness or injury since your last check up or sports physical?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an ongoing or chronic illness?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been hospitalized overnight?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had surgery?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you currently taking any prescription or non prescription (over the counter) medications or pills or using an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?               | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had a rash or hives develop during or after exercise?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever passed out during or after exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever had chest pain during or after exercise?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you get tired more quickly than your friends do during exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had a racing of your heart or skipped heartbeats?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever had high blood pressure or high cholesterol?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever been told you have a heart murmur?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Has any family member or relative died of heart problems or of sudden death before age 50?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had a severe viral infection (for example myocarditis or mononucleosis) within the last month?              | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Has a physician ever denied or restricted your participation in sports for any heart problems?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have any current skin problems (for example itching, rashes, acne, warts, fungus or blisters)?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever had a head injury or concussion?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you ever been knocked out, become unconscious, or lost your memory?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you ever had a seizure?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you have frequent or severe headaches?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Have you ever had a stinger, burner or pinched nerve?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have you ever become ill from exercising in the heat?   | <input type="checkbox"/> | <input type="checkbox"/> |

- |  | YES / NO                 |                          |
|--|--------------------------|--------------------------|
| 25. Do you cough, wheeze, or have trouble breathing during or after activity?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Do you have asthma?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you have seasonal allergies that require medical treatment?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or positions (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Have you ever had a sprain, strain, or swelling after injury?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you broken or fractured any bones or dislocated any joints?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you ever had any other problems with pain or swelling in muscles, tendons, bones, or joints?  | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, check appropriate line and explain below.

___ Head	___ Elbow	___ Hip
___ Neck	___ Forearm	___ Thigh
___ Back	___ Wrist	___ Knee
___ Chest	___ Hand	___ Shin/Calf
___ Shoulder	___ Finger	___ Ankle
___ Upper Arm		___ Foot

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 32. Do you want to weigh more or less than you do now?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Do you loose weight regularly to meet weight requirements for your sport? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Do you feel stressed out?   | <input type="checkbox"/> | <input type="checkbox"/> |

Record the dates for your most recent immunizations (shots) for:

Tetanus _____	Measles _____
Hepatitis B _____	Chicken Pox _____

**FEMALES ONLY:**

35. When was your first menstrual period? \_\_\_\_\_
36. When was your most recent menstrual period? \_\_\_\_\_
37. How much time do you usually have from the start of one period to the start of another? \_\_\_\_\_
38. How many periods have you had in the last year? \_\_\_\_\_
39. What was the longest time between periods in the last year? \_\_\_\_\_

Explain all "YES" answers from above here: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_