



ATHLETIC PARTICIPATION INFORMATION

Beaverton School District #48

SCHOOL SPONSORED ATHLETIC ACTIVITIES

PARENT/GUARDIAN: Please read with your student athlete. ALL INFORMATION MUST BE COMPLETED

STUDENT ID #: _____ School Attended Last Term _____ SPORT: _____

Student's Name: _____	Male <input type="checkbox"/> Female <input type="checkbox"/>	Current School: _____
Birthdate: _____	Month _____ Day _____ Year _____	Grade in School: _____ Currently Enrolled in _____ Courses: _____
Parent/Guardian Name: _____	Family Physician: _____	Phone Number: _____
Home Address: _____	Health Insurance Provider: _____	
Home Phone: _____ Daytime Phone: _____		
City: _____ Zip Code: _____	Policy No _____	Group No: _____
ALLERGIES, MEDICAL CONDITIONS, ETC. THAT WE SHOULD KNOW ABOUT: _____		

Your son/daughter has expressed a desire to participate in a Beaverton School District #48 athletic activity. The school and district staff require certain information concerning such participation which may be helpful to you. Will you please read and then sign this information form at the bottom of the page and return it to the appropriate school personnel.

1. Each athlete must pay a student participation fee. This fee covers participation only – no insurance included.

2. Oregon's Legislature has passed a law effective with the 2002-03 school year requiring students, who participate in athletics, to pass a physical examination every two years in grades 9-12. The exam must be performed by a licensed physician (M.D. or D.O.) prior to participating in a Beaverton School District athletic program. All Freshman and Juniors will be required to have physicals. Any new student to the district, without a physical in the last two years will be required to submit proof of a physical. If a student sustains an accident, injury or serious illness, the athlete must be cleared by his/her physician prior to participating in any athletic activity.

3. **Medical insurance is required of all students participating in school athletics.** It is understood that Beaverton School District is not liable for any medical, dental, or hospital bills occurring as a result of athletic injuries incurred by a student while participating in a supervised sport, and that such bills, in excess of insurance benefits, shall be the responsibility of the student's parents or guardians.

4. Practice and game equipment, with some exception, will be issued to members of competitive teams. Students will be held monetarily accountable for school equipment issued to them. Future participation may be withheld if restitution is not made.

5. All athletes are expected to conform to the rules of scholastic eligibility, participation, and training rules as prescribed by the Oregon School Activities Association, Beaverton School District, and the athletic coaching staff. (This information will be reviewed by the coaching staff prior to the start of the sport season with each athlete.)

6. When teams travel for games with other schools outside the school district, transportation may be furnished by the school district. When district transportation is provided, athletes must travel both to and from the location of the contest by school-provided transportation unless exceptions are granted by the coach in charge.

7. I hereby give permission for my son/daughter to undergo medical treatment for any injury or illness he/she may sustain or acquire while engaging in interscholastic athletics through Beaverton School District. I understand that the Certified Athletic Trainer and/or Team Physician will perform only those procedures which are within their training, credentialing, and scope of professional practice. Should hospitalization, surgery, or other invasive procedures be required, I understand that attempts will be made to contact me for my consent. In the event that I am unable to be contacted within a reasonable period of time, I authorize any duly licensed medical practitioner to perform such procedures, as may be medically necessary to alleviate the problem.

8. I realize no amount of reasonable supervision or training can eliminate all the dangers of athletic participation and that my child may suffer serious injury as a result of participation in athletic events. Notwithstanding this possibility, and with full knowledge and understanding of the risk of serious injury to my son/daughter as a result of athletic participation, I give my permission for my son/daughter to participate in all sports and activities approved by the Beaverton School District this year. If I have an exception, I have listed them below:

(Exceptions)

9. Certain athletic events may involve overnight stays in hotels, motels or dormitories. During these occasions, supervision will be provided by coaches or parent chaperones. Students will be expected to follow Beaverton School District rules and regulations. Failure to follow those rules may result in the athlete being sent home at the parents' expense and suspended/expelled from the team and school.

Signature: _____

I have obtained the following type of insurance (check one):	
() Private	() Purchased separate coverage through school

Signature of Parent/Guardian

Date

Beaverton School District participates in the Impact concussion management program. Athletes in high risk sports will be administered a cognitive baseline test through the athletic training program. Baseline testing will be utilized in the event of a concussion as a tool to help determine the athlete's ability to return to play. All results are kept confidential and will only be used by the Athletic Trainer, Team Physician and/or necessary medical staff. **If you do not wish to have your child participate in the program please sign below.**

Signature: _____

School Sports Pre-Participation Examination – Part 1: Student or Parent Completes

Revised May 2010

NAME: _____

BIRTHDATE: ____/____/____

ADDRESS: _____

PHONE: (____) _____

Athlete and Parent/Guardian: Please review all questions and answer them to the best of your ability. Explain any YES answers on back.
Medical Provider: Please review with the athlete details of any positive answers.

YES	NO	Don't Know	
			1. Has anyone in the athlete's family died suddenly before the age of 50 years?
			2. Has the athlete ever passed out during exercise or stopped exercising because of dizziness or chest pain?
			3. Does the athlete have asthma (wheezing), hay fever, other allergies, or carry an EPI pen?
			4. Is the athlete allergic to any medications or bee stings?
			5. Has the athlete ever broken a bone, had to wear a cast, or had an injury to any joint?
			6. Has the athlete ever had a head injury or concussion?
			7. Has the athlete ever had a hit or blow to the head that caused confusion, memory problems, or prolonged headache?
			8. Has the athlete ever suffered a heat-related illness (heat stroke)?
			9. Does the athlete have a chronic illness or see a physician regularly for any particular problem?
			10. Does the athlete take any prescribed medicine, herbs or nutritional supplements?
			11. Does the athlete have only one of any paired organ (eyes, kidneys, testicles, ovaries, etc.)?
			12. Has the athlete ever had prior limitation from sports participation?
			13. Has the athlete had any episodes of shortness of breath, palpitations, history of rheumatic fever or tiring easily?
			14. Has the athlete ever been diagnosed with a heart murmur or heart condition or hypertension?
			15. Is there a history of young people in the athlete's family who have had congenital or other heart disease: cardiomyopathy, abnormal heart rhythms, long QT or Marfan's syndrome? (You may write "I don't understand these terms" and initial this item, if appropriate.)
			16. Has the athlete ever been hospitalized overnight or had surgery?
			17. Does the athlete lose weight regularly to meet the requirements for your sport?
			18. Does the athlete have anything he or she wants to discuss with the physician?
			19. Does the athlete cough, wheeze, or have trouble breathing during or after activity?
			20. Are you unhappy with your weight?
			21. FEMALES ONLY
			a. When was your first menstrual period? _____
			b. When was your most recent menstrual period? _____
			c. What was the longest time between menstrual periods in the last year? _____

Parent/Guardian's Statement:

I have reviewed and answered the questions above to the best of my ability. I and my child understand and accept that there are risks of serious injury and death in any sport, including the one(s) in which my child has chosen to participate. I hereby give permission for my child to participate in sports / activities.

I hereby authorize emergency medical treatment and/or transportation to a medical facility for any injury or illness deemed urgently necessary by a registered athletic trainer, coach, or medical practitioner.

I understand that this sports pre-participation physical examination is not designed nor intended to substitute for any recommended regular comprehensive health assessment.

I hereby authorize release of these examination results to my child's school.

Signed: _____
Parent/Guardian

Date: _____

ORS 336.479, Section 1 (3) "A school district shall require students who continue to participate in extracurricular sports in grades 7 through 12 to have a physical examination once every two years." Section 1(5) "Any physical examination required by this section shall be conducted by a (a) physician possessing an unrestricted license to practice medicine; (b) licensed naturopathic physician; (c) licensed physician assistant; (d) certified nurse practitioner; or a (e) licensed chiropractic physician who has clinical training and experience in detecting cardiopulmonary diseases and defects."

School Sports Pre-Participation Examination – Part 2: Medical Provider Completes

Revised May 2010

NAME: _____				BIRTHDATE: ____/____/____	
Height: _____	Weight: _____	% Body Fat (optional): _____	Pulse: _____	BP: ____/____(____/____/____)	
Vision: R 20/____ L 20/____		Corrected: Y N	Pupils: Equal _____ Unequal _____	Rhythm: Regular _____ Irregular _____	

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Appearance			
Eyes / Ears / Nose / Throat			
Lymph Nodes			
Heart: Pericardial activity			
1 st & 2 nd heart sounds			
Murmurs			
Pulses: brachial / femoral			
Lungs			
Abdomen			
Skin			

MUSCULOSKELETAL

Neck			
Back			
Shoulder / arm			
Elbow / forearm			
Wrist / hand			
Hip / thigh			
Knee			
Leg / ankle			
Foot			

* Station-based examination only

CLEARANCE

_____ Cleared

_____ Cleared after completing evaluation / rehabilitation for: _____

_____ Not cleared for: _____ Reason: _____

Recommendations: _____

Name of Medical Provider: _____ (print or type) Date: _____

Address: _____ Phone: (____) _____

Signature of Medical Provider: _____

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