SEATTLE SCHOOL DISTRICT ATHLETIC DEPARTMENT
ATHLETIC REGISTRATION & PHYSICAL FORM

I.D. Number

SECTION I: INFORMATION **F** **M** **Birth Date** **Grade**

Student-Athlete Name: ____
(Last) (First) (Middle Initial)

School attended last year: ______________________________________ Private School Student: Y N
School Name City/State

SECTION II: 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 up to a maximum benefit of $25,000 for each injury including the following minimum provisions:

- Surgery. 80% of usual and customary charges/$5,000 maximum
- Physician Visits. . . . . $30 per day
- Emergency Room. . . . . Usual and customary charges/$2,500 maximum
- X-Rays. 80% of usual and customary charges
- Dental. . . . . $200 per tooth

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(Option 1) Mid School — My son/daughter is currently enrolled in the approved Seattle School District regular school insurance program.

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(Option 1) High School — My son/daughter is currently enrolled in the approved Seattle School District Athletic Insurance Program.

OR

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(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 Number

PARENT/GUARDIAN SIGNATURE: ____ DATE: ______________________

(Please check option 1 or option 2 and sign above.)

SECTION III: INJURY RISK/PARENT PERMISSION

Student may participate in a maximum of three (3) sports, one per sport season. Please indicate your choice by writing the name of sport opposite the season. **My son/daughter has permission to participate in school district athletic/activity programs as indicated below:**

FALL: X Country…Football…Golf…G/Soccer…G/Swimming*…B/Tennis*…Volleyball __________________________
WINTER: Basketball...Gymnastics...B/Swimming*....Swimming...Wrestling __________________________
SPRING: Baseball...G/Golf*...B/Soccer...Softball...G/Tennis*...Tennis...Track __________________________
Cheer Squad ☐ Yes ☐ No Additional Sport/Activity __________________________
*4A School Only

Some athletic activities are more dangerous than others. Accidents can happen and risks of serious injury do exist. The severity of such injury can range from minor cuts, bruises, sprains, and muscle strains to more serious injuries to the body's bone joints, ligaments, tendons, or muscles, to catastrophic injuries to the head, neck and spinal cord. On rare occasions, injuries can be so severe as to result in total disability, paralysis, or death. Your signature indicates that you have completed all information accurately, that you have been advised of the injury risks that could occur during any properly supervised program activity, and that you have given permission for your son/daughter to participate. **Your signature also indicates that you have received and read a student policy and procedure handbook.**

Student Signature: ____ Date: ________________

Parent/Guardian Signature: ____ Date: ________________

SECTION IV: INFORMATION UPDATE

Home Address ____ Home Phone ____________

Person to Call in Case of Injury ____________________Relationship __________ Phone : ___________

Medications in Use __________________________________ Medicine Allergic to: _______________

Family Doctor _______________________________________ Doctor's Phone Number ____________

Mother's Name _________________________Home Phone ____________Bus. Phone: ____________

Father's Name _________________________Home Phone ___________Bus. Phone : ____________

SECTION V: MEDICAL EMERGENCY AUTHORIZATION

Name of Student Athlete _________________________________ School __________________

As parent or legal guardian, I authorize the team physician or in his/her absence, a qualified physician to examine the above-named student and in the event of injury, to administer emergency care and to arrange for any consultation he/she deems necessary to ensure proper care of any injury. Every effort will be made to contact parent/guardian to explain the nature of the problem prior to any involved treatment.

I understand that I will assume full responsibility for payment of any services rendered, including transporting by emergency vehicles if necessary.

PARENT/GUARDIAN SIGNATURE:_________________________________DATE: ____________

SECTION VI: PHYSICAL EXAMINATION

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

Washington Interscholastic Activities Association (WIAA) regulation 18.13.0 requires that prior to the first practice for participation in interscholastic athletics in a middle level school, and prior to the first practice for participation in a high school, 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. A student wishing to participate at the high school level for the first time is required to have a new physical regardless of when that student had his/her last physical. This physical examination must include, but not necessarily be limited to**:**

A. 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 therefrom.

B. Documentation of satisfactory examination of the cardiopulmonary system.

C. Documentation of satisfactory sport-specific orthopedic screening examination.

D. 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 18.13.5 states that for each subsequent thirteen-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.

The Seattle School District provides Equal Educational and Employment Opportunity without regard to race, creed, color, national origin, sex, handicap/disability or sexual orientation. If you have questions regarding the district's Affirmative Action Policy, call 252-0175

PREPARTICIPATION HISTORY AND PHYSICAL EXAMINATION

This form is not required as long as the conditions of 18.13.0 are met.

Name: ___________________________________ Birth Date: ___________________ Exam Date: _______________

Address: ____ City: ________________________ Zip: __________________

Phone: __________________________ Sport: _____________________________

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?

***** ATHLETE SHOULD NOT WRITE BELOW THIS LINE *****

EXAMINER’S COMMENTS ON ALL “YES” ANSWERS (refer to question number):

____

____

____

____

____

PHYSICAL EXAMINATION

Name: ____

Age:____________ Pulse:____________

Height:____________ Blood Pressure:____________

Weight:____________ Visual Acuity: Left 20/_______

Right 20/ _______

Optional

Urinalysis:
Body Fat %
HCT:
EST VO2 Max:
Audiometry:

Normal			Abnormal	
☐	1.	Head	☐	______
☐	2.	Eyes (pupils), ENT	☐	______
☐	3.	Teeth	☐	______
☐	4.	Chest	☐	______
☐	5.	Lungs	☐	______
☐	6.	Heart	☐	______
☐	7.	Abdomen	☐	______
☐	8.	Genitalia	☐	______
☐	9.	Neurologic	☐	______
☐	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: ________________________________