

Middle School Sports Physical Examination Clearance

Student's name _____
(Last) (First) (MI)

ASB fee paid: _____
Sports fee paid: S1 S2 S3 S4
Family paid: _____

Gender: Male Female Date of Birth _____ Grade _____

Primary parent/guardian _____ Email _____

Primary phone # _____ Secondary Phone # _____

Secondary parent/guardian _____ Email _____

Primary phone # _____ Secondary Phone # _____

Physician _____ Phone _____

Physical Examination/Clearance (completed by physician only)

Medications _____
Vision _____ Height _____ Weight _____
Eyes _____ BP _____ HR _____ UA _____
Ears _____ GI / GU _____
Nose _____ Allergies (food/medicines) _____
Teeth _____ Skin _____
Heart _____ Musculoskeletal _____
Lungs _____ Neurological _____

Do you know any reason why this child should not participate in the athletic programs in the Lake Washington School District?

No Yes If yes, please explain _____

Assessment: Full Participation Limited Participation (describe limitations below)

Physician's signature _____ Date of exam _____

Health History – check all that apply (To be completed by parent/guardian)

Asthma _____ Convulsions _____ Neck or back surgery _____ Contact lenses _____
Concussion _____ Heart problems _____ False teeth or bridge _____
Epilepsy _____ Dehydration problems _____ Abnormal bleeding _____
Sprains/strains/fractures _____
Anything else _____
Current medications _____
Preferred hospital _____

Emergency Contact: (Relative or neighbor) _____ Phone #: _____

Other phone numbers where we can reach you in emergency _____

Insurance Information: I have medical coverage for doctor's services and hospitalization and will continue to keep it in force throughout the sports season. I accept full responsibility for the cost of treatment for any injury my student may suffer while participating in the athletic program.

Insurance Company Name _____ Policy # _____

Medical Authorization: As a parent or legal guardian, I authorize a qualified physician to examine the above named student in the event of an injury to administer emergency care and arrange for any consultation by a specialist, including a surgeon, deemed necessary to ensure proper care of any injury. Every effort will be made to contact the parent or guardian to explain the nature of the problem prior to any involved treatment.

We certify that we have read, understand, and agree to the following:

Refund policy (student initials) _____ (parent initials) _____
Athlete Drug, Alcohol, Tobacco, Hazing & Conduct Codes (student initials) _____ (parent initials) _____
Concussion Sheet- Lysted Law (student initials) _____ (parent initials) _____

By signing below I agree that all information provided is true and correct.

Student signature

Parent signature

Date

Lake Washington School District No. 414

ATHLETICS EMERGENCY INFORMATION

Student's name _____ Date of Birth _____
(Last) (First) (MI)

Parent/Guardian's name _____ Address _____

Home Phone: _____ Father's Phone: _____ Mother's Phone: _____

Name of Insurance Company: _____ Policy Number: _____

Two persons you recommend we call in the event you cannot be reached:

Name & Relationship: _____ Phone: _____

Name & Relationship: _____ Phone: _____

Hospital Preference: _____

Physician Preference - Name: _____ Phone: _____

Date of last Tetanus Booster: _____ Allergies: _____

MEDICAL AUTHORIZATION: As a parent or legal guardian, I authorize a qualified physician to examine the above named student in the event of an injury to administer emergency care and arrange for any consultation by a specialist, including a surgeon, deemed necessary to ensure proper care of any injury. Every effort will be made to contact the parent or guardian to explain the nature of the problem prior to any involved treatment.

Parent/Guardian Signature: _____ Date: _____

PERMISSION TO SHARE INFO/PHOTOS WITH MEDIA (check) LWSD only Local News None

Lake Washington School District No. 414

Student/Parent Concussion and Sudden Cardiac Arrest Awareness Form

The Lake Washington School District believes participation in athletics improves physical fitness, coordination, self-discipline, and gives students valuable opportunities to learn important social and life skills.

With this in mind it is important that we do as much as possible to create and maintain an enjoyable and safe environment. As a parent/guardian or student you play a vital role in protecting participants and helping them get the best from sport.

Player and parental education in this area is crucial which is the reason for the Concussion Management and Sudden Cardiac Arrest Awareness pamphlet you received. Refer to it regularly.

This form must be signed annually by the parent/guardian and student prior to participation in Lake Washington School District athletics. If you have questions regarding any of the information provided in the pamphlet, please contact the athletic director at your school.

I HAVE RECEIVED, READ AND UNDERSTAND THE INFORMATION PRESENTED IN THE CONCUSSION RECOGNITION AND SUDDEN CARDIAC ARREST AWARENESS PAMPHLETS.

_____	_____	_____
<i>Student Name (Printed)</i>	<i>Student Name (Signed)</i>	<i>Date</i>
_____	_____	_____
<i>Parent Name (Printed)</i>	<i>Parent Name (Signed)</i>	<i>Date</i>