

## Participation Tri-City College Prep Athletic

### Student Information

Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

### Waiver of Insurance

This memorandum of insurance is to certify that an athletic insurance plan has been offered to us through Tri-City College Prep High School.

We are aware of the said plan; but have chosen to use our own insurance company for the 2018-2019 school year. **Please Note: Student must have insurance before tryouts in order to participate in athletics at Tri-City Prep High School.**

Insurance Company \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### School Insurance

We have elected to buy school insurance offered to us by Tri-City College Prep. High School for the 2018-2019 school year. We have completed the insurance request form and turned it in to the administrative office.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### Athletic Permission Form

I/We give our permission for \_\_\_\_\_ to participate in organized interscholastic athletics, realizing that such activity may involve the potential for injury, which is inherent in all sports. I/We acknowledge that even with the best coaching, use of the most advanced protective equipment and strict observance of the rules, injuries are still a possibility. On rare occasions, the injuries can be so severe as to result in total disability, paralysis, quadriplegia, or even death.

I/We acknowledge that I/We have read and understand this warning, and we agree to hold Tri-City College Prep High School harmless should an accident or injury occur.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

**Name of Student:** \_\_\_\_\_

**Physical Examination**

**Please Note: Arizona Interscholastic Association regulations prohibit acceptance of physical exams by Doctors of Chiropractic or Naturopathic MD.**

Physicians: Please complete all the information below.

Height: \_\_\_\_\_ Vision (R) 20/ \_\_\_\_\_ Vision

Weight: \_\_\_\_\_ (L) 20/ \_\_\_\_\_ Corrected: Y/N

BP: \_\_\_\_\_ (B) 20/ \_\_\_\_\_ (circle one)

BP Reference Range:      Vision Reference Range:      Is corrected or uncorrected vision better than 20/50 with both eyes?

10-12 y/o, > 125/80  
12-13 y/o, > 135/85  
16-18 y/o, > 140/90

Cardiopulmonary Examination:      Normal      Abnormal      Explain

Lungs	_____	_____	
Pulses	_____	_____	
Heart	_____	_____	

Musculoskeletal Screening:

Neck	_____	_____	
Shoulder	_____	_____	
Elbow	_____	_____	
Wrist	_____	_____	
Hand	_____	_____	
Back	_____	_____	
Knee	_____	_____	
Ankle	_____	_____	
Foot	_____	_____	

Tanner Stage: (Optional)      1      2      3      4      5

Hernia Evidence:      Y/N (circle one)

Other: (Physical examination pertinent to historical information)

**Recommendation:**

\_\_\_\_\_ Pass  
\_\_\_\_\_ Pass with restrictions: \_\_\_\_\_  
\_\_\_\_\_ Deferred until: \_\_\_\_\_  
\_\_\_\_\_ Failed. Reason: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Physical Examination Dr

**Tri-City College Prep. High School  
Physical Examination Summary  
Participation in Interscholastic Sports Activities**

Name: \_\_\_\_\_ Male/Female (circle one)  
Age: \_\_\_\_\_ Grade: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Circle the sports you play:  
Phone: \_\_\_\_\_  
Family Physician: \_\_\_\_\_ Basketball Soccer Softball  
Physician Phone: \_\_\_\_\_ Volleyball Rowing Golf \_\_\_\_\_

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Instructions: Please review all the questions below and answer them as truthfully as possible. It is important to include all pertinent information. Parents or guardians must sign below.

Current Medications:

\_\_\_\_\_

\_\_\_\_\_

- |  | Circle One | Explain |
|--|------------|---------|
|  | Yes        | No      |
| 1. Has anyone in your family died suddenly before the age of 50? | Yes        | No      |
| 2. Have you ever passed out or felt dizzy during exercise?       | Yes        | No      |
| 3. Do you have asthma or allergies?                              | Yes        | No      |
| 4. Have you ever broken a bone, worn a cast, or injured a joint? | Yes        | No      |
| 5. Have you ever been knocked out (concussion)?                  | Yes        | No      |
| 6. Do you have a chronic illness or see a doctor regularly?      | Yes        | No      |
| 7. Do you have only one of any normally paired organ?            | Yes        | No      |

**For Women Only:**

8. How old were you when you had your first period? \_\_\_\_\_
9. Do you have regular periods? Yes No

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I have reviewed the above questions with my son or daughter and I give permission for my child to undergo a pre-participation physical evaluation and to participate in sports. **I understand the physicians my child may see may be of the opposite gender.**

Signature of Parent or Guardian: \_\_\_\_\_