Cashmere Public Schools

1. GENERAL INFORMATION SCHOOL YEAR – 2015-2016

STUDENT'S NAME _____
(Last Name) (First Name) (Middle Initial)

DATE OF BIRTH _____ **GRADE** _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING QUESTIONS:

_____ Are you currently living with your parent(s)?

_____ If no, are you living with your legal guardian?

_____ Are you currently living within the Cashmere School District boundaries?

_____ Are you now or have you ever been a foreign exchange student?

_____ If yes, have you graduated from your equivalent school?

_____ Were you a transfer student last year? If yes, what was the date of your entrance to the Cashmere School District? _____/_____/_____
mo. day year

SPORT(S) TURNING OUT FOR:

(PLEASE CIRCLE)

FALL = FB VB GSC XC CH

WINTER = BBB GBB WR CH

SPRING = BB SB TS TR BSC

What school did you attend last year? _____

Name of School _____ _____
(Date withdrew)

Location of School _____ _____
(State)

2. ATHLETIC CODE & HEAD CONCUSSION INFORMATION

I have received and read the following:

(Please check)

☐ Athletic Code — I understand and agree to follow the terms of the athletic code

☐ Head Concussion Form — I understand the information on the head concussion form

☐ Sudden Cardiac Arrest Form — I understand the information on the sudden cardiac arrest form

X_____
STUDENT SIGNATURE

X_____
PARENT SIGNATURE

FALSIFYING SIGNATURES ON ANY REQUIRED FORM WILL BE CAUSE FOR LOSS OF ELIGIBILITY FOR ACTIVITY

3. SCHOOL ATHLETIC EMERGENCY INFORMATION/MEDICAL CLEARANCE

Student Name _____

Date of birth _____ Male____ Female____ Grade ____ Age____

Address _____ Telephone _____

Parent(s) Guardian(s) _____ Work phone _____ Who? _____

Parent home phone _____ Who? Emergency phone _____ Who? _____

Family Physician _____ Telephone _____

It is required that participants in interscholastic athletic activities carry insurance for injury and/or accidents. Many private insurance policies and employer sponsored group insurance plans DO NOT cover interscholastic athletic related injuries. ONE OF THE OPTIONS below must be completed to be eligible to participate in our interscholastic athletics:

(1) _____ I have accident/medical insurance that covers my son/daughter during interscholastic athletics:

Insurance Company _____ Policy No. _____

(2) **OR . . .**

_____ I have purchased school insurance that covers my son/daughter during interscholastic athletics:

(Please check)

☐ School Time Plan (covers all sports EXCEPT high school football)

☐ Full Time Plan (covers all sports EXCEPT high school football)

☐ Football plan (covers ONLY football)

In the event of serious injury and your family doctor cannot be contacted, and if we are unable to contact one or the other parent, does the coaching staff/athletic trainer have your permission to seek medical attention from the nearest physician?

(Please check Yes or No)

Yes ☐ No ☐ If your answer is NO, please state below the procedure you wish the coaching staff/athletic trainer to follow:

_____

_____

_____

I authorize release of the health care practitioner's (family physician and/or athletic physical provider) exam findings and other pertinent medical data as it relates to the participation of my child in Cashmere School District sports activities. I understand that the physical exam documentation will be kept on file in the appropriate school's office.

X_____ X_____

PARENT SIGNATURE ***DATE***

4A. PHYSICAL QUESTIONNAIRE

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(s) turning out for: _____

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 a tonsillectomy?
	g	☐	☐	Have you ever had any injuries requiring treatment by a physician?
	h	☐	☐	Do you have any organs missing other than tonsils (appendix, eye, kidney, testicle, etc.)?
2		☐	☐	Are you presently taking ANY medications (including birth control pills, vitamins, 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 sever 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 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, or 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?

Age _____
Height _____
Weight _____
Pulse _____
Blood Pressure _____
Visual Acuity:
Left 20/_____
Right 20/_____

----ATHLETE SHOULD NOT WRITE BELOW THIS LINE-----

EXAMINER'S COMMENTS ON ALL "YES' ANSWERS (refer to question number):

_____

_____

_____

_____

4B. MEDICAL CLEARANCE

STUDENT NAME: _____ **DOB** _____

Examiner's Section
_____ Complete physical (Required prior to middle school level and high school level)
_____ Annual Update

Are there any significant findings the school medical/coaching staff should be aware of:

Height _____

_____ Head/neck/spine injuries
_____ Musculoskeletal injuries
_____ Cardiopulmonary condition
_____ Other medical conditions (describe)
_____ Loss of paired organs
_____ Medications (list below)
_____ Allergic to medicines, insect bites, other

Weight _____

Please explain any of the above: _____

Blood Pressure _____ Vision results (If any) _____

Immunizations given during this physical _____ Date _____

Assessment:

_____Full participation

_____Limited participation (describe limitations, restrictions): _____

Participation NOT ALLOWED (list reasons and sports): _____

Recommendations (equipment, bracing, taping, rehabilitation, etc): _____

Wrestling: Circle recommended weight class (minimum recommended body fat % for males = 7%)
High School: 103 112 119 125 130 135 140 145 152 160 171 189 215 275
Middle School: 64-75 70-82 87 92 97 103 112 119 125 130 135 140 145 152 160 171 189 215 Over 215 Others: _____

Date X _____ *Examiner's Signature X* _____
Examiner's Name (Print) X _____