



**Student Athlete Participation Consent Packet**

**PLEASE COMPLETE FORM IN ITS ENTIRETY**

**4233/'4234**

Part I-Pre-Participation Physical Evaluation (Medical History)

Part II-Pre-Participation Physical Evaluation (Physical Exam)

Part III-Acknowledgment of Risk and Insurance Statement

Part IV-Emergency Permission Form To Treat A Minor

Westminster Catawba Christian School  
2650 India Hook Rd  
Rock Hill, SC 29732

# I. PRE-PARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

This **MEDICAL HISTORY FORM** must be completed by parent (or guardian) and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

Student's Name: (print) \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Grade \_\_\_\_\_ School: **Westminster Catawba Christian School**

Personal Physician \_\_\_\_\_ Phone \_\_\_\_\_

Parent/Guardian contact: \_\_\_\_\_ Relationship \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_



Explain "Yes" answers in the box below\*\*. Circle questions you don't know the answers to. Any "Yes" answers to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in practices, games or matches.

	YES	NO		YES	NO				
1 Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	13 Have you ever gotten unexpectedly short of breath with any type of exercise?	<input type="checkbox"/>	<input type="checkbox"/>				
2 Have you been hospitalized overnight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>				
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>				
3 Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	14 Do you use any special protective or corrective equipment or devices (for example, knee brace, special neck roll, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>				
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	15 Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>				
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured or bruised any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>				
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>				
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, check appropriate box and explain below.						
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip				
Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh				
Has any family member been diagnosed with enlarged heart (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelopathy (Brugada syndrome, etc), Marfan's syndrome or abnormal heart rhythm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee				
Have you had a severe viral infection in the last month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf				
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle				
4 Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot					
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	16 Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>				
If yes, how many times? _____			Do you lose weight regularly to meet weight requirements for your sport? Do you have a weigh in?	<input type="checkbox"/>	<input type="checkbox"/>				
When was the last concussion? _____			17 Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>				
How severe was each one? (Explain below)	<input type="checkbox"/>	<input type="checkbox"/>	18 Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>				
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Females Only</b>						
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	19 When was your first menstrual period?	_____					
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>	When was your most recent menstrual period?	_____					
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	How much time do you usually have from the start of one period to the start of another?	_____					
5 Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>	How many periods have you had in the last year?	_____					
6 Are you under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>	What was the longest time between periods in the last year?	_____					
7 Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	<i>An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question 3 above), as identified in the form, should be restricted from further participation until the individual is examined and cleared</i>						
8 Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>	<b>**EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary)</b>						
9 Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1" style="width: 100%; height: 100%;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>						
10 Do you have any current skin problems?	<input type="checkbox"/>	<input type="checkbox"/>							
11 Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>							
12 Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>							

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither Westminster Catawba Christian School nor the coaching staff assumes any responsibility in case an accident occurs .If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student. If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

Student Signature: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

## II. PRE-PARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAM

Student's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (\_\_\_\_\_/\_\_\_\_\_, \_\_\_\_/\_\_\_\_)

Vision R 20/\_\_\_\_\_ L 20/\_\_\_\_\_ Corrected: Y N Pupils: Equal Unequal

	NORMAL	ABNORMAL FINDINGS	Initials*
<b>MEDICAL</b>			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position.			
Heart-Auscultation of the heart in the standing position.			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

**CLEARANCE**

- Cleared
- Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

*The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.*

Name (print/type) \_\_\_\_\_ Date of Examination: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Signature: \_\_\_\_\_

Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or games/matches.

### III. ACKNOWLEDGEMENT OF RISK AND INSURANCE STATEMENT

(To be completed and signed parent/guardian)

I give permission for \_\_\_\_\_ (name of child/ward) to participate in any of the following sports that are not crossed out: baseball, basketball, cheerleading, cross country, football, golf, swimming/diving, tennis, volleyball, other (identify sports).

I have reviewed the individual eligibility rules and I am aware that with the participation in sports comes the risk of injury to my child/ward. I understand that the degree of danger and the seriousness of the risk varies significantly from one sport to another with contact sports carrying the higher risk. I have had an opportunity to understand the risk inherent in sports through meetings, written handouts, or some other means. He/she has student accident insurance available through the school (yes no); has athletic participation insurance coverage through the school (yes no); is insured by our family policy with:

Name of Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_

I am aware that participating in sports will involve travel with the team. I acknowledge and accept the risks inherent in the sport and with the travel involved and with this knowledge in mind, grant permission for my child/ward to participate in the sport and travel with the team.

By this signature, I hereby consent to allow the physician(s) and other health care provider(s) selected by myself or the school to perform a pre-participation examination on my child and to provide treatment for any injury or condition resulting from participating in athletics/activities for his/her school during the school year covered by this form. I further consent to allow said physician(s) or health care provider(s) to share appropriate information concerning my child that is relevant to participation in athletics and activities with coaches and other school personnel as deemed necessary.

Additionally, I give my consent and approval for the above named student's picture and name to be printed in any high school or WCCS athletic program, publication or video.

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### IV. EMERGENCY PERMISSION FORM TO TREAT A MINOR

(To be completed and signed parent/guardian)

**STUDENT'S NAME** \_\_\_\_\_ **GRADE** \_\_\_\_\_ **AGE** \_\_\_\_\_

Please list any significant health problems that might be significant to a physician evaluating your child in case of an emergency  
\_\_\_\_\_  
\_\_\_\_\_

Please list any allergies to medications, etc. \_\_\_\_\_  
\_\_\_\_\_

Has student been prescribed an inhaler or epipen? \_\_\_\_\_

Is student presently taking medication? \_\_\_\_\_ If so, what type? \_\_\_\_\_

Does student wear contact lenses? \_\_\_\_\_ Please list date of last tetanus shot \_\_\_\_\_

**EMERGENCY AUTHORIZATION:** In the event that I (parent/guardian) cannot be reached in an emergency, I hereby give permission to physicians selected by the coaches and staff of WCCS to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for the person named above.

Emergency Contact (other than parent/guardian) \_\_\_\_\_ Relationship \_\_\_\_\_

Daytime phone number (where to reach contact in emergency) \_\_\_\_\_

Evening time phone number (where to reach contact in emergency) \_\_\_\_\_

*\*Emergency Permission Form may be reproduced to travel with respective teams and is acceptable for emergency treatment if needed.*

I certify all the above information is correct \_\_\_\_\_

Parent/Legal Guardian Signature