



Middle School Sports Pre-Participation Checklist Full Seasons

Thank you for your interest in participating in Middle School Sports, a partnership of Willamalane Park and Recreation District and Springfield Public Schools. Here is information to get you started:

- Each sports fee is \$55
- Scholarships are available (please include your partial payment)
- Transportation is provided by Springfield Public Schools
- General sports calendar:
 - Volleyball - FALL
 - Flag Football - FALL
 - Basketball - WINTER
 - Soccer - SPRING

In order to be eligible to participate in Middle School Sports each student is required to have:

- _____ **Registration/Scholarship form with payment**
- _____ **Annual Medical History form**
- _____ **SPS Liability Notice**
- _____ **A current pre-participation examination (physical)**

Sports physicals are to be completed prior to participating in Middle School Sports programs. Physicals are valid for two years. Please see your school nurse for information about obtaining a current physical.

Return this packet with payment to your middle school

Questions? Contact:

**Mike Allison
Athletic Coordinator
(541) 736-4516
mikea@willamalane.org**



Lista de Participación para los deportes de las Escuelas Secundarias

Gracias por su interés en participar en los deportes de las Escuelas Secundarias, una colaboración entre El Distrito de Parques y Recreación de Willamalane y Las Escuelas Públicas de Springfield.

Aquí es la información para comenzar:

- **Cada deporte cuesta \$55**
- **Becas son disponibles (Favor de incluir su pago parcial)**
- **Se incluye la transportación pagada por Las Escuelas Públicas de Springfield**
- **Calendario general de los deportes:**
 - **Voleibol – Otoño**
 - **Fútbol Americano (banderas) – Otoño**
 - **Baloncesto –Invierno**
 - **Fútbol - Primavera**

Para ser eligible participar en los deportes de Las Escuelas Secundarias, cada estudiante necesita:

- _____ **Forma de Registración/Beca con pago**
- _____ **Forma de la historia medica, cada año**
- _____ **Noticias de Liabilidad SPS**
- _____ **Examen física antes de participar que sea corriente**

Un examen física tiene que completar antes de participar en cualquier programa de deportes de Las Escuelas Secundarias. Duran dos años. Favor de hablar con la enfermera o asistente de salud en su escuela para obtener más información.

Regrese este paquete con su pago a su escuela.

¿Preguntas? Llame a:

Mike Allison

**Coordinador de los deportes de
Las Escuelas Secundarias**

(541) 736-4516

mikea@willamalane.org



Student Name _____ Sex: M F DOB _____

Grade _____ Current Sport _____

**Please
fill in
every
blank.**

Parent/Guardian Name _____

Address _____ Home Phone _____

Mother/Guardian Workplace _____ Work Phone _____

Father/Guardian Workplace _____ Work Phone _____

Health Insurance Co. _____

Group No. _____ Policy I.D. No. _____

Date of Last Physical _____ Family Physician _____ Phone _____

Emergency contact when a parent/guardian cannot be reached: _____ Work Phone _____

Name _____ Home Phone _____

Have you had any illness, injury or surgery that restricted activity in the past 12 months? Yes No

If Yes, please describe _____

Have you had any illness lasting more than one week in the past 12 months? Yes No

If Yes, please describe _____

Have you been examined by a physician or hospitalized in the past 12 months? Yes No

If Yes, please describe _____

Are you currently under a physician's care? Yes No

If Yes, please describe _____

Have you had an MRI, CT, bone scan, or X-ray in the past 12 months? Yes No

If Yes, please describe _____

Are you currently taking any medication? Yes No

If Yes, please describe _____

Please check "Y" (yes) or "N" (no) for all of the following. Explain any "Y" answers in the space provided (or use back of sheet). Include the current status of the condition. Please list any allergies or current medications.

Have you ever experienced:

CONDITION	Y	N	If Yes, Date	Explanation (Please complete this for any YES answer.)
Concussions	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Stingers	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sprains	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Strains	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Glasses/contacts	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Allergies (bees?)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Please list any medical conditions the staff should be aware of: _____

I give permission for my student to participate in ALL sports.

Yes No **If No, explain:**

I hereby give permission to the District 19 representative to approve hospitalization, secure treatment or medication for the above named student. In case of an emergency and I cannot be reached, I hereby give my permission to the physician selected by the representative to order injections, anesthesia, or surgery for the student named above. Any direction to the contrary will be specified on the back of this form.

Parent/Guardian Signature _____ Date _____



Student Name _____

School _____

SPS Liability Notice

Grade _____

Safety Concerns:

The selection of school activity programs available to students ranges from student council to a variety of athletic teams. Regardless of the program that you select, your involvement will lead to enjoyment as a member of a group and greater confidence in your ability to meet challenges.

In some activities you may need to develop stamina and skills through a program of physical conditioning. If specialized protective equipment is to be worn, the articles should fit and be used in the intended manner. You must tell the activity teacher or coach if protective clothing and/or equipment is ill fitting or in need of repair.

Teachers and coaches review rules and procedures to promote safety. However, you have a responsibility to use good judgment and to notify the activity program teacher or coach of any possible safety hazard.

Teacher and coaches are qualified and experienced. However, accidents will occur. Running, jumping, throwing, kicking, etc., are a normal part of some activity programs. It is important that you and your parent or guardian discuss with your activity teacher or coach the nature of the training program, the type of competition and the possible injuries that may occur.

The signature below indicates that the student and parent/guardian have read this letter, and recognize that there are potential hazards in participating in activities, and that both will comply with District procedures and rules.

Insurance Arrangements:

PLEASE CHECK ONE:

_____ I desire for my son/daughter to take out the athletic insurance policy offered through the district.

**The athletic insurance policy requires additional forms available in your school office.*

_____ My son/daughter is fully covered by insurance carried by the parents/guardian and the school will not be liable for any injury that occurs during athletic practices, contests, or travel to and from athletic events.

Name of the company with which insured: _____

Signature of Parent or Guardian

Date

Springfield Public Schools
525 Mill Street
Springfield, Oregon 97477
541-726-3331

School Sports Pre-Participation Examination June 2005

NAME: _____ **BIRTHDATE:** _____ / _____ / _____

ADDRESS: _____ **PHONE:** (_____) _____

Athlete and Parent/Guardian: Please review all questions and answer them to the best of your ability.
Physician: Please review with the athlete details of any positive answers.

YES	NO	Don't Know	
_____	_____	_____	1. Has anyone in the athlete's family died suddenly before the age of 50 years?
_____	_____	_____	2. Has the athlete ever passed out during exercise or stopped exercising because of dizziness or chest pain?
_____	_____	_____	3. Does the athlete have asthma (wheezing), hay fever, or coughing spells during or after exercise?
_____	_____	_____	4. Has the athlete ever broken a bone, had to wear a cast, or had an injury to any joint?
_____	_____	_____	5. Does the athlete have a history of a concussion (getting knocked out) or seizures?
_____	_____	_____	6. Has the athlete ever suffered a heat-related illness (heat stroke)?
_____	_____	_____	7. Does the athlete have a chronic illness or see a physician regularly for any particular problem?
_____	_____	_____	8. Does the athlete take any prescribed medicine, herbs or nutritional supplements?
_____	_____	_____	9. Is the athlete allergic to any medications or bee stings?
_____	_____	_____	10. Does the athlete have only one of any paired organ (eyes, ears, kidneys, testicles, ovaries, etc.)?
_____	_____	_____	11. Has the athlete ever had prior limitation from sports participation?
_____	_____	_____	12. Has the athlete had any episodes of shortness of breath, palpitations, history of rheumatic fever or unusual fatigability?
_____	_____	_____	13. Has the athlete ever been diagnosed with a heart murmur or heart condition or hypertension?
_____	_____	_____	14. Is there a history of young people in the athlete's family who have had congenital or other heart disease: cardiomyopath, abnormal heart rhythms, long QT or Marfan's syndrome? (You may write "I don't understand these terms" and initial this item, if appropriate.)
_____	_____	_____	15. Has the athlete ever been hospitalized overnight or had surgery?
_____	_____	_____	16. Does the athlete lose weight regularly to meet the requirements for your sport?
_____	_____	_____	17. Does the athlete have anything he or she wants to discuss with the physician?
_____	_____	_____	18. Does the athlete cough, wheeze, or have trouble breathing during or after activity?
_____	_____	_____	19. Does the athlete have asthma?
			20. FEMALES ONLY
			a. When was your first menstrual period? _____
			b. When was your most recent menstrual period? _____
			c. What was the longest time between menstrual periods in the last year? _____

(Explain any YES answers on back.)

Parent/Guardian's Statement:

I have reviewed and answered the questions above to the best of my ability. I and my child understand and accept that there are risks of serious injury and death in any sport, including the one(s) in which my child has chosen to participate. I hereby give permission for my child to participate in sports / activities.

I hereby authorize emergency medical treatment and/or transportation to a medical facility for any injury or illness deemed urgently necessary by a licensed athletic trainer, coach, or medical practitioner.

I understand that this sports pre-participation physical examination is not designed nor intended to substitute for any recommended regular comprehensive health assessment.

I hereby authorize release of these examination results to my child's school.

Signed: _____ **Date:** _____
Parent/Guardian

As per ORS 336.479, Section 1 (3) "A school district shall require students who continue to participate in extracurricular sports in grades 7 through 12 to have a physical examination once every two years." Section 1(5) "Any physical examination required by this section shall be conducted by a (a) physician possessing an unrestricted license to practice medicine; (b) licensed naturopathic physician; (c) licensed physician assistant; (d) certified nurse practitioner; or a (e) licensed chiropractic physician who has clinical training and experience in detecting cardiopulmonary diseases and defects."

School Sports Pre-Participation Examination

NAME: _____				BIRTHDATE: ____ / ____ / ____	
Height: _____	Weight: _____	% Body Fat (optional): _____	Pulse: _____	BP: ____ / ____ (____ / ____)	
Vision: R 20/____ L 20/____	Corrected: Y N	Pupils: Equal ____ Unequal ____	Rhythm: Regular ____ Irregular ____		

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart: Pericardial activity			
1st & 2nd heart sounds			
Murmurs			
Pulses: brachial/femoral			
Lungs			
Abdomen			
Skin			

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

* Station-based examination only

CLEARANCE

_____ Cleared

_____ Cleared after completing evaluation/rehabilitation for: _____

_____ Not cleared for: _____ Reason: _____

Recommendations: _____

Name of physician (print/type): _____ Date: ____ / ____ / ____

Address: _____ Phone: (____) _____

Signature of Physician: _____

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