Preparticipation Physical Evaluation

HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam

Name

Sex

Age

Grade

School

Sport(s)

Date of birth

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

Do you have any allergies?

☐ Yes  ☐ No  ☐ Other

☐ Medicines

☐ Pollens

☐ Food

☐ Stinging Insects

Explain “Yes” answers below. Circle questions you don’t know the answers to.

GENERAL QUESTIONS

1. Has a doctor ever denied or restricted your participation in sports for any reason?

☐ Yes  ☐ No

2. Do you have any ongoing medical conditions? If so, please identify below:

☐ Asthma  ☐ Anemia  ☐ Diabetes  ☐ Infections

☐ Other:

3. Have you ever spent the night in the hospital?

☐ Yes  ☐ No

4. Have you ever had surgery?

☐ Yes  ☐ No

5. Have you ever passed out or nearly passed out during or after exercise?

☐ Yes  ☐ No

6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?

☐ Yes  ☐ No

7. Does your heart ever race or skip beats (irregular beats) during exercise?

☐ Yes  ☐ No

8. Has a doctor ever told you that you have any heart problems? If so, check all that apply:

☐ High blood pressure

☐ A heart murmur

☐ High cholesterol

☐ A heart infection

☐ Kawasaki disease

☐ Other:

9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)

☐ Yes  ☐ No

10. Do you get lightheaded or feel more short of breath than expected during exercise?

☐ Yes  ☐ No

11. Have you ever had an unexplained seizure?

☐ Yes  ☐ No

12. Do you get more tired or short of breath more quickly than your friends during exercise?

☐ Yes  ☐ No

13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?

☐ Yes  ☐ No

14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?

☐ Yes  ☐ No

15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?

☐ Yes  ☐ No

16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?

☐ Yes  ☐ No

BONE AND JOINT QUESTIONS

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?

☐ Yes  ☐ No

18. Have you ever had any broken or fractured bones or dislocated joints?

☐ Yes  ☐ No

19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?

☐ Yes  ☐ No

20. Have you ever had a stress fracture?

☐ Yes  ☐ No

21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)

☐ Yes  ☐ No

22. Do you regularly use a brace, orthotics, or other assistive device?

☐ Yes  ☐ No

23. Do you have a bone, muscle, or joint injury that bothers you?

☐ Yes  ☐ No

24. Do any of your joints become painful, swollen, feel warm, or look red?

☐ Yes  ☐ No

25. Do you have any history of juvenile arthritis or connective tissue disease?

☐ Yes  ☐ No

MEDICAL QUESTIONS

26. Do you cough, wheeze, or have difficulty breathing during or after exercise?

☐ Yes  ☐ No

27. Have you had an asthma attack?

☐ Yes  ☐ No

28. Is there anyone in your family who has asthma?

☐ Yes  ☐ No

29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?

☐ Yes  ☐ No

30. Do you have chronic sinusitis or chronic sinusitis with nasal polyps?

☐ Yes  ☐ No

31. Have you had infectious mononucleosis (mono) within the last month?

☐ Yes  ☐ No

32. Do you have any rashes, pressure sores, or other skin problems?

☐ Yes  ☐ No

33. Have you had a herpes or MRSA skin infection?

☐ Yes  ☐ No

34. Have you ever had a head injury or concussion?

☐ Yes  ☐ No

35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?

☐ Yes  ☐ No

36. Do you have a history of seizure disorder?

☐ Yes  ☐ No

37. Do you have headaches with exercise?

☐ Yes  ☐ No

38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?

☐ Yes  ☐ No

39. Have you ever been unable to move your arms or legs after being hit or falling?

☐ Yes  ☐ No

40. Have you ever become ill while exercising in the heat?

☐ Yes  ☐ No

41. Do you get frequent muscle cramps while exercising?

☐ Yes  ☐ No

42. Do you or someone in your family have sickle cell trait or disease?

☐ Yes  ☐ No

43. Have you had any problems with your eyes or vision?

☐ Yes  ☐ No

44. Have you had any eye injuries?

☐ Yes  ☐ No

45. Do you wear glasses or contact lenses?

☐ Yes  ☐ No

46. Do you wear protective eyewear, such as goggles or a face shield?

☐ Yes  ☐ No

47. Do you worry about your weight?

☐ Yes  ☐ No

48. Are you trying to or has anyone recommended that you gain or lose weight?

☐ Yes  ☐ No

49. Are you on a special diet or do you avoid certain types of foods?

☐ Yes  ☐ No

50. Have you ever had an eating disorder?

☐ Yes  ☐ No

51. Do you have any concerns that you would like to discuss with a doctor?

☐ Yes  ☐ No

52. Have you ever had a menstrual period?

☐ Yes  ☐ No

53. How old were you when you had your first menstrual period?

☐ Yes  ☐ No

54. How many menstrual periods have you had in the last 12 months?

☐ Yes  ☐ No

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

Signature of athlete

Signature of parent/guardian

Date

# Preparticipation Physical Evaluation

## THE ATHLETE WITH SPECIAL NEEDS:
### SUPPLEMENTAL HISTORY FORM

<table>
<thead>
<tr>
<th>Date of Exam</th>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Date of birth</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Grade</th>
<th>School</th>
<th>Sport(s)</th>
</tr>
</thead>
</table>

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Do you regularly use a brace, assistive device, or prosthetic?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Do you use any special brace or assistive device for sports?</td>
<td></td>
<td></td>
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<tr>
<td>8. Do you have any rashes, pressure sores, or any other skin problems?</td>
<td></td>
<td></td>
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<tr>
<td>9. Do you have a hearing loss? Do you use a hearing aid?</td>
<td></td>
<td></td>
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<tr>
<td>10. Do you have a visual impairment?</td>
<td></td>
<td></td>
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<tr>
<td>11. Do you use any special devices for bowel or bladder function?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Do you have burning or discomfort when urinating?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Have you had autonomic dysreflexia?</td>
<td></td>
<td></td>
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<tr>
<td>14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Do you have muscle spasticity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Do you have frequent seizures that cannot be controlled by medication?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Explain “yes” answers here

---

Please indicate if you have ever had any of the following.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-ray evaluation for atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dislocated joints (more than one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easy bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enlarged spleen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteopenia or osteoporosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bowel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bladder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in arms or hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in legs or feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness in arms or hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness in legs or feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent change in coordination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent change in ability to walk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spina bifida</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latex allergy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Explain “yes” answers here

---

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

Signature of athlete __________________________ Signature of parent/guardian __________________________ Date ________________
**Preparticipation Physical Examination**

**Physical Examination Form**

**Name** ___________________________________________  **Date of birth** __________________________

**Physician Reminders**
1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

**Examination**

<table>
<thead>
<tr>
<th></th>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

**Medical**

<table>
<thead>
<tr>
<th>Examination</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marfan stigmata</td>
<td></td>
<td></td>
</tr>
<tr>
<td>kyphoscoliosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>high-arched palate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pectus excavatum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>arachnodactyly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>arm span &gt; height</td>
<td></td>
<td></td>
</tr>
<tr>
<td>hyperlaxity, myopia, MVP, aortic insufficiency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes/ears/nose/throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pupils equal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymph nodes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Murmurs (auscultation standing, supine, +/- Valsalva)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location of point of maximal impulse (PMI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simultaneous femoral and radial pulses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitourinary (males only)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSV, lesions suggestive of MRSA, linea corporis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurologic*</td>
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<td></td>
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</tbody>
</table>

**Musculoskeletal**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Neck</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shoulder/arm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elbow/forearm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wrist/hand/fingers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip/thigh</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leg/ankle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot/toes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functional</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duck-walk, single leg hop</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

*Consider (6) exam if in private setting. Having third party present is recommended.

*Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction
☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ____________________________________________________________

☐ Not cleared
☐ Pending further evaluation
☐ For any sports
☐ For certain sports ____________________________________________________________

Reason ____________________________________________________________

Recommendations ____________________________________________________________

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ___________________________________________  Date __________________________

Address ______________________________________  Phone __________________________ 

Signature of physician ____________________________________________________________

Preparticipation Physical Evaluation
CLEARANCE FORM

Name ___________________________ Sex ☐ M ☐ F Age ___________ Date of birth ___________

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ____________________________

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports

Reason ____________________________

Recommendations __________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ___________________________________________________________________________________ Date ________________

Address _________________________________________________________________________________________ Phone _________________________

Signature of physician _____________________________________________________________________________________________________, MD or DO

EMERGENCY INFORMATION

Allergies __________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Other information __________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Georgia High School Association
Student/Parent Concussion Awareness Form

SCHOOL: Malcom Bridge Middle School

DANGERS OF CONCUSSION
Concussions at all levels of sports have received a great deal of attention and a state law has been passed to address this issue. Adolescent athletes are particularly vulnerable to the effects of concussion. Once considered little more than a minor “ding” to the head, it is now understood that a concussion has the potential to result in death, or changes in brain function (either short-term or long-term). A concussion is a brain injury that results in a temporary disruption of normal brain function. A concussion occurs when the brain is violently rocked back and forth or twisted inside the skull as a result of a blow to the head or body. Continued participation in any sport following a concussion can lead to worsening concussion symptoms, as well as increased risk for further injury to the brain, and even death.

Player and parental education in this area is crucial – that is the reason for this document. Refer to it regularly. This form must be signed by a parent or guardian of each student who wishes to participate in GHSA athletics. One copy needs to be returned to the school, and one retained at home.

COMMON SIGNS AND SYMPTOMS OF CONCUSSION
- Headache, dizziness, poor balance, moves clumsily, reduced energy level/tiredness
- Nausea or vomiting
- Blurred vision, sensitivity to light and sounds
- Fogginess of memory, difficulty concentrating, slowed thought processes, confused about surroundings or game assignments
- Unexplained changes in behavior and personality
- Loss of consciousness (NOTE: This does not occur in all concussion episodes.)

BY-LAW 2.68: GHSA CONCUSSION POLICY: In accordance with Georgia law and national playing rules published by the National Federation of State High School Associations, any athlete who exhibits signs, symptoms, or behaviors consistent with a concussion shall be immediately removed from the practice or contest and shall not return to play until an appropriate health care professional has determined that no concussion has occurred. (NOTE: An appropriate health care professional may include licensed physician (MD/DO) or another licensed individual under the supervision of a licensed physician, such as a nurse practitioner, physician assistant, or certified athletic trainer who has received training in concussion evaluation and management.

a) No athlete is allowed to return to a game or a practice on the same day that a concussion (a) has been diagnosed, OR (b) cannot be ruled out.

b) Any athlete diagnosed with a concussion shall be cleared medically by an appropriate health care professional prior to resuming participation in any future practice or contest. The formulation of a gradual return to play protocol shall be a part of the medical clearance.

By signing this concussion form, I give MBMS permission to transfer this concussion form to the other sports that my child may play. I am aware of the dangers of concussion and this signed concussion form will represent myself and my child during the 2019-2020 school year. This form will be stored with the athletic physical form and other accompanying forms required by the DOREE COUNTRY SCHOOL SYSTEM.

I HAVE READ THIS FORM AND I UNDERSTAND THE FACTS PRESENTED IN IT.

_________________________  ____________________________  __________________
Student Name (Printed)      Student Name (Signed)       Date

_________________________  ____________________________  __________________
Parent Name (Printed)        Parent Name (Signed)        Date

(Revised: 2/19)
Oconee County Schools
Athletic Handbook Acknowledgment Form

Student Athlete: __________________________
Sport(s): __________________________

As the parent or guardian of this student, I have read and understand the Oconee County Schools Athletic Handbook. I recognize that my child must abide by all procedures therein in order to remain eligible to participate in the athletic program and understand that violating the procedures will result in the loss of that privilege. Therefore, I support and accept the policies and regulations of the school board, including those that prohibit the use of alcohol, drugs, and tobacco, and the procedures of the OCS Athletic Handbook while my child is involved in any athletic activity.

Signature of Parent or Guardian __________________________ Date ____________

As a student participant in the OCS athletic program, I have read and understand the Oconee County Schools Athletic Handbook. I recognize that I must abide by all procedures therein in order to remain eligible to participate in the athletic program and understand that violating the procedures will result in the loss of that privilege. Therefore, I support and accept the policies and regulations of the school board, including those that prohibit the use of alcohol, drugs, and tobacco, and the procedures of the OCS Athletic Handbook while I am involved in any athletic activity.

Signature of Student Athlete __________________________ Date ____________

The athlete is expected to abide by the Oconee County Schools Student Code of Conduct as well as the Athletic Code of Ethics contained in this handbook.

Athlete Signature: __________________________ Date: ____________

Parent or Guardian: __________________________ Date: ____________
Malcom Bridge Middle School
2500 Malcom Bridge Road
Bogart, GA 30622
(706) 310-1992
MEDICAL RELEASE & TRAVEL PERMISSION FORMS

MEDICAL RELEASE

Should your son or daughter have an accident or become ill while participating in the extracurricular activity named, we need your permission to obtain medical help from our medical personnel or local hospital if we are unable to reach you. In addition, it is important that you understand that it is necessary for each athlete to have adequate medical insurance coverage should an injury occur while participating in an athletic competition or practice. The lower portion of this section, when completed, confirms that your child is covered by medical insurance and that you give your authorization to seek medical attention if necessary. If you do not have medical insurance coverage for your child, school insurance must be purchased before your child can participate in any practices or competitions at MBMS. The basic school insurance covers all sports except football. If your child is participating in football and is not covered under a medical insurance policy, specific school football insurance must be purchased. Students may not participate in athletics without proof of medical insurance.

MEDICAL RELEASE

The Malcom Bridge Middle School __________________________ (Activity or Sport)
Sponsor has my permission to obtain medical aid from __________________________ (doctor or hospital)
for __________________________. My son/daughter is covered by __________________________ (Student’s Name)
__________________________ (Company Name)
__________________________ (Policy Number)
and I accept responsibility for medical services provided.

Signature of Parent/Guardian __________________________ Date __________________________

TRAVEL PERMISSION

I hereby give my permission for my son/daughter __________________________ to go on planned trips associated with his/her participation and as a member of the __________________________ team.

I understand that these trips will be under supervision of an employee of the Oconee County Public Schools. By execution of this permission slip, the undersigned acknowledges that the proposed trips will be so supervised but may occur at indoor/outdoor locations other that the properties owned by the Oconee County Schools and may expose participants to non-school environment and to the actions of non-school personnel, which environment and personnel are beyond the control of Oconee County Public Schools. The undersigned further acknowledges that these trips may involve motor vehicle travel away from school premises and that the method of transportation is at the discretion of Oconee County Schools. Student athletes may not drive their own vehicles. The students will be expected to travel with his/her team throughout the entire sport as stipulated by the coach or sponsor.

It will be the decision of the head coach of that particular sport or sponsor of the sport whether a student may be released from traveling to or from the school. For a student to be granted permission to travel other than with his/her group or team, the parent/guardian must give each coach a written request prior to that particular activity.

If the coach does agree to release the student to return with the parent/guardian, the parent/guardian must personally see the head coach at the time the student is to be released.

The undersigned hereby releases, individually and as a parent and natural guardian of his/her participating child, Malcom Bridge Middle, Oconee County Board of Education, and any and all employees of same from liability for death, personal injury, and/or property damage that may be sustained by the above referenced student while involved in this travel and related activities.

(Signature of Parent/Guardian) __________________________ (Date) __________________________

Student Emergency Information Card

To Be Completed by Athlete/Parent

Full Name of Parent/Guardian: __________________________
Address: __________________________ Home Phone: __________________________
City: __________________________ Zip: __________________________
Contact if Parent Cannot be Reached: __________________________ Phone: __________________________
Relationship to Athlete: __________________________ Phone: __________________________
Family Doctor: __________________________ Phone: __________________________
Current Grade as of Date Submitted: __________________________