
(PRINT) LAST NAME,

FIRST NAME

ST. JOHN'S LUTHERAN SCHOOL
ATHLETIC PARTICIPATION PACKET

2009 – 2010

Approved by:

Date:

Male Female (Circle one)

Grade in August 2009 _____

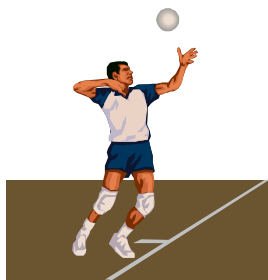
CIRCLE THE SPORT OR SPORTS YOU PLAN TO PARTICIPATE IN



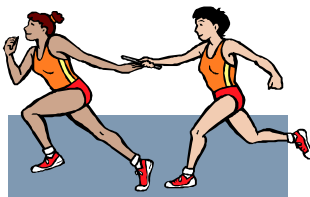
FLAG FOOTBALL



BASKETBALL



VOLLEYBALL



TRACK AND FIELD



CHEERLEADING

ST. JOHN'S ATHLETIC PARTICIPATION PACKET

- 1. Policy**
- 2. Pre-Participation Evaluation (to be completed by parent and student)**
- 3. Physical Examination Form**
- 4. Medical Information Release Form**

ST. JOHN'S LUTHERAN SCHOOL
ORANGE, CALIFORNIA

PHYSICAL EVALUATION FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETIC PROGRAM

INTENT

St. John's Lutheran School recognizes the value of participation in athletic activities, both in physical fitness and in sportsmanship, teambuilding and leadership development. It is the intent of St. John's to provide this opportunity to students who meet and maintain eligibility based on academic, behavioral, and physical qualifications.

POLICY

- A. The coach, with direction from the Athletic Director, is responsible for checking and enforcing the rules and regulations which apply to his/her athletes.
- B. The coach must submit his/her list of eligible athletes to the Athletic Director *not less than two weeks prior to the first game of the season*. All athletes' names must be the full given name (no nicknames) and spelled correctly.
- C. In order to be eligible for participation in interscholastic athletics, the student must undergo a **pre-participation physical evaluation** and be certified as being physically fit for participation in interscholastic sports.
 - 1. the physical evaluation is valid for one year from the date that it was administered, after which time the student must undergo another physical evaluation in order to continue participation
 - 2. the annual physical must be administered by either a **licensed physician, physician's assistant, licensed osteopathic physician, or certified advanced registered nurse practitioner**. Evaluation may require release of medical information from other providers, necessitating the "Medical Information Release Form" attached to this policy.
 - 3. the sports physical evaluation should be dated after June 1 of the year; otherwise, on the date that the physical evaluation expires (one year from the date that it was administered), the student will immediately become ineligible for participation.
 - 4. the completed physical evaluation form, signed by the healthcare professional who administered the evaluation, and the signed parent/guardian consent form for student participation in interscholastic sports must be on file with the **Athletic Director *prior to the first practice and not less than two weeks prior to the first game of the season***.
- D. If the student is ill and missing school for three (3) successive days or more OR has suffered an injury requiring more than basic first aid (i.e., required attendance and treatment by a licensed healthcare professional), he/she must bring a note from his/her healthcare professional stating that he/she is fit to participate again. The student must be in attendance for one-half day (i.e., four academic hours) on the day of athletic practice or game or on Friday before any weekend games, or must have made *prior* arrangements regarding the absence.
- E. The parent/guardian must have read, signed and submitted the school "Permission to Travel & Medical Authorization" for his/her child/ward to participate in interscholastic athletic activities *prior to the first practice and not less than two weeks prior to the first game of the season*.

DATE

____/____/____

ST. JOHN'S LUTHERAN SCHOOL
ORANGE, CALIFORNIA

PRE-PARTICIPATION PHYSICAL EVALUATION

NAME: _____ PHONE: _____

ADDRESS: _____ CITY: _____ ZIP: _____

SEX: [M] [F] AGE: _____ DATE OF BIRTH: _____ GRADE: _____

PERSONAL PHYSICIAN: _____ PHONE: _____

HISTORY: must be completed by student and parent/guardian prior to examination by healthcare professional (circle)

- 1. Has a doctor ever denied or restricted your participation in sports for any reason? YES NO
2. Have you had a medical illness or injury since your last checkup or sports physical? YES NO
3. Have you ever had... head/brain injury, concussion... YES NO
4. Have you every had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss practice or game? YES NO
5. Have you had any broken/fractured bones or dislocated joints? YES NO
6. Have you had any bone or joint injury that required xrays, MRI, CT scan, surgery, injections, rehabilitation, physical therapy, brace, cast or crutches? YES NO
7. Have you ever had numbness, tingling, weakness or been unable to move your arms or legs after being hit or falling? YES NO
8. Are you happy with your weight? YES NO
9. Are you trying to gain or lose weight? YES NO
10. Has anyone recommended that you change your weight or eating habits? YES NO
11. Have you ever had a menstrual period? YES NO
12. How old were you when you had your first period?
13. How many periods have you had in the last year?
14. Other concerns you wish to discuss with the Dr.? YES NO

IF "YES" TO # 4, 5, OR 6, INDICATE AFFECTED AREA/BODY PART:

Table with 4 columns: head, neck, upper back, lower back; chest, shoulder, upper arm, elbow; forearm, wrist, hand, finger(s); hip, thigh, knee, shin/calf; ankle, foot, toe(s)

IF "YES" TO ANY QUESTION, DESCRIBE/EXPLAIN BELOW -

Four horizontal lines for describing answers to 'YES' questions.

PRESENTLY... Check any that apply:

- Wears glasses contacts dental appliance (circle: crown bridge partial plate full plate braces)
Taking medication (specify what, why)
Under a doctor's care (why, for how long)
Name of physician Phone

I (we) hereby state that, to the best of my knowledge, my/our answers to the above questions are correct and complete.
Student's signature Parent's/guardian's signature Date

DATE

____/____/____

ST. JOHN'S LUTHERAN SCHOOL
ORANGE, CALIFORNIA

PHYSICAL EVALUATION & EXAMINATION

Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

STUDENT'S NAME _____ DATE OF BIRTH ____/____/____

HT _____ WT _____ PULSE _____ BP SUPINE, SITTING, STANDING

VISION (R) 20/____ (L) 20/____ CORRECTED? YES NO PUPILS: PERLA NON-PERLA

MEDICAL	WNL	ABNORMAL FINDINGS
Appearance		
Eyes, ears, nose, throat		
Hearing		
Lymph nodes		
Heart		
Murmurs		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulders/arms		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knees		
Lower leg/ankle		
Foot/toes		

CLEARANCE

Cleared without restriction

Cleared after completing evaluation/treatment for _____

Not cleared due to _____

Recommendations: _____

I hereby certify that this student was examined by me on this date, and based on the medical history and physical examination, he/she may compete in supervised athletic activities except those crossed out below.

BASKETBALL♦ CHEERLEADING♦ TRACK♦ VOLLEYBALL♦ FLAG FOOTBALL

PRINTED NAME OF PHYSICIAN / PROVIDER

PHYSICIAN/ PROVIDER SIGNATURE

PHYSICIAN/ PROVIDER PHONE

