

WASHOUGAL SCHOOL DISTRICT NO. 112
4855 Evergreen Way, Washougal, WA 98671

Office Use Only	
_____	Parent Permission
_____	Insurance
_____	Physical
_____	Athletic Code
_____	ASB Card
_____	2.0 GPA
_____	Medical Release
_____	FB Warning Waiver
_____	WR/WT Permit
_____	Participation Fee

Fall	Winter	Spring
Volleyball	Girls Basketball	Track and Field
Cross Country	Boys Basketball	Softball
Girls Soccer	Wrestling	Girls Tennis
Boys Golf		Girls Golf
Boys Tennis		Baseball
Football		Boys Soccer

ATHLETIC PARTICIPATION PACKET

Student Name: _____ Birth date: _____
 Student Number: _____ Grade: _____
 School: WHS EHS CCMS JMS Other _____
 Previous School: _____
 Street Address: _____ City: _____ Zip: _____
 Mailing Address: _____ City: _____ Zip: _____
 Father's Name: _____ Mother's Name: _____
 Home Phone: _____ Home Phone: _____
 Work Phone: _____ Work Phone: _____
 Cell Phone: _____ Cell Phone: _____
 Custodial parent (if applicable): _____

(Parent to complete the above information.)

INSURANCE STATUS FORM

I approve of my son's/daughter's participation in: *(name of sport(s))*

Fall	Winter	Spring

which includes the regularly scheduled trips as a team member. I realize there is a certain degree of danger of physical injury inherent in sports participation although it is understood that every effort will be made to minimize such danger through proper coaching and training techniques. I accept full responsibility for the cost of treatment for any injury which he/she may suffer while taking part in the program.

Accident insurance is required for all students participating in our sports program. Insurance is available through the school if you do not have a plan of your own or would like to supplement your own coverage. The rates vary depending on the coverage you choose and/or need. Accidental dental coverage is available for a full year.

We have adequate medical insurance, which will be kept in force through each sport season.

_____ *Insurance Company* _____ *Policy Number*

We have adequate accidental dental insurance, which will be kept in force through each sport season.

_____ *Insurance Company* _____ *Policy Number*

Signature of Parent or Guardian

I hereby grant permission for my son/daughter to participate in the above activities for the _____ school year, and agree to promote the Activities Code.

Parent/Guardian Signature _____
Date _____

Student Activities Pledge and Information Card

STUDENT NAME _____ BIRTH DATE _____ SEX _____

ACTIVITY _____

STUDENT ACTIVITY PLEDGE (*See handbook, Activities Code, for further description*)

- | | |
|------------------------------------|---|
| 1. Maintain scholastic eligibility | 5. Be a credit to your school |
| 2. Abide by Activities Code | 6. Promote good sportsmanship |
| 3. Be adequately insured | 7. Purchase an ASB card to support activities |
| 4. Take proper care of equipment | 8. Pay user fee prior to turn out. |

Student Signature: _____ **Date:** _____

STUDENT: READ, INITIAL AND SIGN

I am aware that playing or practicing to play/participate in any sport can be a dangerous activity involving **MANY RISKS OF INJURY**. I understand that the dangers and risks of playing or practicing to play/participate in sports include but are not limited to death, serious neck and spinal injuries (which may result in complete or partial paralysis), brain damage, serious injury to virtually all internal organs, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the muscular skeletal system, and serious injury or impairment to other aspects of my body, general health and well-being. I understand that the dangers and risks of playing or practicing to play/participate in sports may result not only in serious injury, but in a serious impairment of my future abilities to earn a living, to engage in other business, social and recreational activities, and generally to enjoy life.

Because of the dangers of participating in sports, I recognize the importance of following coaches' instructions regarding playing techniques, training and other team rules, etc., and to agree to obey such instructions.

Student Signature: _____ **Date:** _____

PARENT/GUARDIAN: READ, INITIAL AND SIGN

As the parent/legal guardian of _____, I have read _____
(Student)

Washougal School District's warning and understand, its terms. I understand that all sports can involve many **RISKS OF INJURY**, including, but not limited to, those risks outlined.

The following to be completed only if sport is **football, wrestling, or baseball**:

I specifically acknowledge that _____

[indicate sport(s)]

is a **VIOLENT CONTACT SPORT(S)** involving even greater risk of injury than other sports.

(Parent/guardian initial)

Signature of Parent/ Legal Guardian: _____ **Date :** _____

Completed Doctors Clinic Physical – Date: _____

Washington Interscholastic Activities Association (WIAA)
PREPARTICIPATION HISTORY AND PHYSICAL EXAMINATION

Name _____ Birth Date _____ Exam Date _____

Address _____

Phone () _____ Sport(s) _____
City *Zip*

HISTORY

- | | Yes | No | |
|-----|-----|--------------------------|---|
| 1. | a. | <input type="checkbox"/> | <input type="checkbox"/> Have you had any illness/injury recently, or do you have an illness/injury now? |
| | b. | <input type="checkbox"/> | <input type="checkbox"/> Have you had a medical problem, illness or injury since your last exam? |
| | c. | <input type="checkbox"/> | <input type="checkbox"/> Do you have any chronic or recurrent illness? |
| | d. | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had any illness lasting more than a week? |
| | e. | <input type="checkbox"/> | <input type="checkbox"/> Have you ever been hospitalized overnight? |
| | f. | <input type="checkbox"/> | <input type="checkbox"/> Have you had any surgery other than tonsillectomy? |
| | g. | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had any injuries requiring treatment by a physician? |
| | h. | <input type="checkbox"/> | <input type="checkbox"/> Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc.)? |
| 2. | | <input type="checkbox"/> | <input type="checkbox"/> Are you presently taking ANY medications (including birth control pills, vitamins, aspirin, etc.)? |
| 3. | | <input type="checkbox"/> | <input type="checkbox"/> Do you have ANY allergies (medicine, bees, foods, or other factors)? |
| 4. | a. | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had chest pain, dizziness, fainting, passing out during or after exercise? |
| | b. | <input type="checkbox"/> | <input type="checkbox"/> Do you tire more easily or quickly than your friends during exercise? |
| | c. | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had any problem with your blood pressure or your heart? |
| | d. | <input type="checkbox"/> | <input type="checkbox"/> Have any close relatives had heart problems, heart attack or sudden death before they were age 50? |
| 5. | | <input type="checkbox"/> | <input type="checkbox"/> Do you have any skin problems (acne, itching, rashes, etc.)? |
| 6. | a. | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had fainting, convulsions, seizures, or severe dizziness? |
| | b. | <input type="checkbox"/> | <input type="checkbox"/> Do you have frequent severe headaches? |
| | c. | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had a “stinger” or “burner” or “pinched nerve”? |
| | d. | <input type="checkbox"/> | <input type="checkbox"/> Have you ever been “knocked out” or “passed out”? |
| | e. | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had a neck or head injury? |
| 7. | | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems? |
| 8. | | <input type="checkbox"/> | <input type="checkbox"/> Have you had asthma, or trouble breathing, or cough during or after exercise? |
| 9. | a. | <input type="checkbox"/> | <input type="checkbox"/> Do you wear eyeglasses, contact lenses or protective eye wear? |
| | b. | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had any problem with your eyes or vision? |
| 10. | | <input type="checkbox"/> | <input type="checkbox"/> Do you wear any dental appliance such as braces, bridge, plate, retainer? |
| 11. | a. | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had a knee injury? |
| | b. | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had an ankle injury? |
| | c. | <input type="checkbox"/> | <input type="checkbox"/> Have you ever injured any other joint (shoulder, wrist, fingers, etc.)? |
| | d. | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had a broken bone (fracture)? |
| | e. | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had a cast, splint, or had to use crutches? |
| | f. | <input type="checkbox"/> | <input type="checkbox"/> Must you use special equipment for competition (pads, braces, neck roll, etc.)? |
| 12. | | <input type="checkbox"/> | <input type="checkbox"/> Has it been more than five years since your last tetanus booster shot? |
| 13. | | <input type="checkbox"/> | <input type="checkbox"/> Are you worried about your weight? |
| 14. | | <input type="checkbox"/> | <input type="checkbox"/> FEMALES: Have you any menstrual problems? |
| 15. | | <input type="checkbox"/> | <input type="checkbox"/> Have you any medical concerns about participating in your sport? |

(Athlete should not write below this line)

EXAMINER’S COMMENTS ON ALL “YES” ANSWERS (refer to question number):

PHYSICAL EXAMINATION

Optional

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

Urinalysis:

Body Fat %:

HCT:

EST VO2 Max:

Audiometry:

Normal

- 1. Head
- 2. Eyes (pupils), ENT
- 3. Teeth
- 4. Chest
- 5. Lungs
- 6. Heart
- 7. Abdomen
- 8. Genitalia
- 9. Neuralgic
- 10. Skin
- 11. Physical Maturity
- 12. Spine, Back
- 13. Shoulders, Upper extremities
- 14. Lower extremities

Abnormal

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

- Assessment:** Full participation
 Limited participation (*describe limitations, restrictions*):
 Participation contraindicated (*list reason*):

ATTENTION WRESTLERS! If applicable:

Wrestling Weight Recommendations: I recommend that the student designated above should not be allowed to wrestle any weight less than the indicated classification circled herewith:

Junior High	78	85	90	95	100	105	110	115	120	125	130	137	145	154	164	175	210	275
High School	103	112	119	125	130	135	140	145	152	160	171	189	215	275				

Note: Contestants will wrestle "scratch" weight throughout the entire season. There will be no weight allowance.

Unlimited must weigh over 190.

Date _____

Examiner's Signature _____

Examiner's Phone () _____

Examiner's Name Printed _____

MEDICAL EMERGENCY AUTHORIZATION FORM

TO BE COMPLETED BY PARENT AND RETURNED TO ATHLETIC OFFICE

Name of Student Athlete _____

As Parent or Legal Guardian, I authorize the team physician or, in his absence, a qualified physician to examine the above-named student and in the event of injury to administer emergency care and to arrange for any consultation by a specialist, including a surgeon, he deems necessary to insure proper care of any injury. Every effort will be made to contact parent or guardian to explain the nature of the problem prior to any involved treatment.

Name: _____
Signature of Parent/Guardian Date

Parent(s) Home Phone: _____ Business Phone: _____

Emergency Contact Person

Name: _____ Phone: _____

Relationship of contact person: _____

Physician's Name: _____ Phone: _____

Insurance Company: _____ Policy # _____

FOR SCHOOL USE ONLY:

Completed Form Received _____
Date Name

Duplicate Copy Distribution to _____

on _____
Date

Insurance coverage by parents Yes _____ No _____ Unknown _____

One copy filed in Student Permanent Record: _____
Date By Name