

**MIDDLETOWN PUBLIC SCHOOLS**  
**Student Athletic Participation Form**

NAME \_\_\_\_\_ GRADE \_\_\_\_\_ AGE \_\_\_\_\_

ADDRESS \_\_\_\_\_

SPORT \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

HOME PHONE \_\_\_\_\_ EMERGENCY PHONE \_\_\_\_\_

SCHOOL: HIGH SCHOOL \_\_\_\_\_ MONHAGEN \_\_\_\_\_ TWIN TOWERS \_\_\_\_\_

Dear Parent/Guardian:

Your child has expressed a desire to participate in our interscholastic athletic program. It is important that you and your child understand the goals of the program and agree to abide by the rules established by the district for the benefit of those who participate as players, students, and representatives of their community.

Interscholastic sports are a part of a broad extracurricular program designed to teach students certain skills and reinforce concepts of self-worth (achievement), cooperative effort (teamwork), and ethical decision-making (sportsmanship).

All participants must receive a sports physical examination before participating in interscholastic athletics. The results of the examination shall be valid for qualifying a student's participation for a period of 12 continuous months. The sports physical may be performed by the school physician or nurse practitioner, or your own family physician. Please indicate on the Annual Health History form whether you would like the school to provide the physical exam or if you would like to have your family physician perform the examination.

The coaching staff and other responsible school officials will do everything within reason to protect your child against injury, including the provision of appropriate equipment, safe facilities, and training designed to reduce the impact of accidents. However, an injury may occur and on a very rare occasion may be serious and disabling. If you are concerned about this possibility, you should discuss this with your child's coach.

School insurance for the medical treatment of school sports related injuries is applicable only after the parents' health insurance, if any, has been paid. Our insurance is scheduled, excess coverage and generally will not pay the full cost of treatment. The cost of medical benefit insurance on a total basis would be so costly as to effectively eliminate the program.

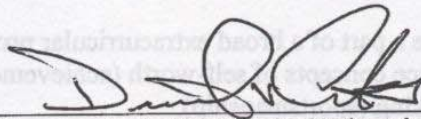
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During the first three team meetings, the coach will explain the attendance, training, and eligibility rules for participation. In addition to the strict observance of these rules, your child will be expected to continue to observe all regular school obligations of good citizenship and academic achievement.

Not all students who wish to participate in the interscholastic athletics program may be able to do so. Occasionally the number of players on a team is limited by the availability of team positions, equipment available, or the number of coaches. Occasionally if cuts are made, they will be made on the basis of skill, readiness for competition, and observance of the rules. Children will be permitted to compete when they have met all eligibility standards.

School equipment issued to your child for participation is his or her responsibility, and must be returned promptly upon request. Reimbursement from the student will be expected for loss or destruction beyond ordinary wear and use.

We hope your child has a rewarding athletic experience. Your support and encouragement of your child's endeavor will contribute to that success.



Director of Health, Physical Education, and Athletics

I have read the information in the above letter and understand both the risks of injury to, and the responsibilities of my child while participating in the interscholastic athletic program.  
I have made a copy of this document and I give my permission for my child to participate in

\_\_\_\_\_.  
(name of sport and level)

Date \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_

I understand that I will be required to abide by team, school, and other applicable rules in order to maintain my eligibility to participate in interscholastic athletics.

Date \_\_\_\_\_ Student Signature \_\_\_\_\_

**MIDDLETOWN CITY SCHOOLS – PRE-SPORTS HEALTH HISTORY**  
**This form must be completed by the parent & returned to the Health Office.**

**STUDENT'S NAME:** \_\_\_\_\_ **DOB** \_\_\_\_\_ **GRADE** \_\_\_\_\_  
**SPORT** \_\_\_\_\_ **SCHOOL** \_\_\_\_\_

**GENERAL MEDICAL HISTORY (to be completed by parent or guardian)**

Indicate if your child or family member have or had the following illnesses or conditions by marking **(S)** for student, **(F)** for family (sibling or parent), **(B)** for both or **(NA)** if not applicable in the appropriate box. Please include dates.

Asthma		Heart Disorder	
Respiratory disorder		Diabetes	
Anemia (including sickle cell trait or disease)		History of fainting or dizziness	
High Blood Pressure		Life Threatening Allergy	
Absence of paired organ (eye, kidney)		Concussion Number _____	
Sudden death in family member under age 50		Frequent or severe headaches	
Epilepsy or convulsive disorder		Kidney/Genitourinary disorder	
Osteoporosis/Osteopenia		Heat stroke	
Gastrointestinal Disorder		Mononucleosis	

If **YES** to any of the above, please explain \_\_\_\_\_

Allergies: \_\_\_\_\_ Does your child wear glasses or contact lenses for sports? \_\_\_\_\_

Regular Medications: \_\_\_\_\_ Reason \_\_\_\_\_

Has your child ever been hospitalized? \_\_\_\_\_ Why? \_\_\_\_\_

Has your child ever been denied athletic participation for medical reasons? \_\_\_\_\_ If yes, explain \_\_\_\_\_

**ORTHOPEDIC HISTORY (to be completed by parent or guardian)**

Include any major musculoskeletal injury to the following areas: include sprains, dislocation, fractures, and surgery.

Area	Right	Left	Date	Injury – describe
Foot				
Ankle				
Lower leg				
Thigh				
Hip				
Spine				
Shoulder				
Upper Arm				
Forearm				
Wrist				
Hand				
Head				
Neck				
Other				

Does your child have any other type of illness, injury, or condition that is being monitored by doctor? If yes, please explain \_\_\_\_\_

\_\_\_\_\_ **My child will have their sports exam with their own healthcare provider.**

\_\_\_\_\_ **Please schedule my child's sports exam with Middletown School District's Family Nurse Practitioner.**

I declare the above information to be accurate and a true reflection of my child's physical condition.

Parent or Guardian's Signature \_\_\_\_\_ Date: \_\_\_\_\_



**MIDDLETOWN SCHOOL DISTRICT**  
**PHYSICAL EXAM FOR SPORTS PARTICIPATION**

Name \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Date of last tetanus \_\_\_\_\_

Vision without glasses: R: \_\_\_\_\_ L: \_\_\_\_\_ with glasses/contacts: R: \_\_\_\_\_ L: \_\_\_\_\_

Auditory: R: \_\_\_\_\_ L: \_\_\_\_\_ Urine: (if indicated) protein \_\_\_\_\_ sugar \_\_\_\_\_ other \_\_\_\_\_

**EXERCISE TOLERANCE TESTING:** resting pulse \_\_\_\_\_ pulse after one minute of exercise (jumping jacks) \_\_\_\_\_ pulse after two minutes of rest \_\_\_\_\_

Exam Findings: (check one)	Normal	Not examined	Other (describe)
General body build			
Head & Neck			
Skin & Scalp			
Eyes			
Ears			
Nose & Sinuses			
Teeth/Orthodontic			
Mouth & Throat			
Lungs & Chest			
Heart			
Abdomen			
Hernia			
GU/Tanner stage			
Neurological			
Speech			

Orthopedic Screening: ROM/Stability	Normal	Other (describe)
Ankle/Foot		
Knee/Lower Leg		
Shoulder		
Wrist/Elbow		
Hip/Spine		

Scoliosis \_\_\_\_\_ Hamstring (Fingertip distance from the floor) \_\_\_\_\_ inches

Clinical Findings/Treatment Plan \_\_\_\_\_

This student is cleared to participate in (please check category):

\_\_\_\_\_ All sports, including contact/collision      \_\_\_\_\_ Limited contact/impact sports

\_\_\_\_\_ Strenuous non-contact sports      \_\_\_\_\_ Non-contact/non-strenuous sports

Date of Examination \_\_\_\_\_ Health Care Provider \_\_\_\_\_