TOWN OF FARMVILLE RECREATION DEPARTMENT

P.O. Drawer 368, 116 N. Main Street Farmville, VA 23901
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PHYSICAL EXAMINATION FORM
PART I – ATHLETIC PARTICIPATION

Name: _____ Male: _____ Female: _____
(First) (Last) (MI)

Home Address: _____

Date of Birth: _____ Place of Birth: _____

PART II – MEDICAL HISTORY

(This form must be completed by parent or guardian prior to the physical examination and should be taken with the physical examination form for review by the physician during examination.)

YES NO

1. Have you ever had any of the following? (If yes, please explain)

___ ___ heart murmur: _____

___ ___ high blood pressure: _____

___ ___ other heart problems: _____

___ ___ broken bones: _____

___ ___ weak joints, ankles, or knees: _____

___ ___ concussion: _____

___ ___ operation: _____

___ ___ seizures or epilepsy: _____

___ ___ **2. Have you ever fainted or passed out?** _____

___ ___ **3. Have you ever been knocked out?** _____

___ ___ **4. Have you ever been hospitalized?** _____

___ ___ **5. Have you ever had to stop running after ¼ to ½ miles for chest pain or shortness of breath?**

_____

6. A. Have you ever had significant allergies to:

___ ___ bee stings? _____

___ ___ foods? _____

___ ___ medicine? _____

___ ___ others? _____

B. Do you have prescription for use of:

___ ___ Adrenaline? _____

___ ___ Inhalers? _____

___ ___ Other allergy medicine? _____

___ ___ **C. Do you have asthma?** _____

___ ___ **7. Do you take any medicine regularly?** _____

___ ___ **8. Have you had any illnesses lasting a week or more such as mononucleosis, etc.?**

_____

___ ___ **9. Have you had any blood disorders, including sickle cell trait, anemia, etc.?**

_____

___ ___ **10.Has any family member had a heart attack, heart problems, or sudden death before the age of 50?**

_____

___ ___ **11. Do you wear contact lenses, eyeglasses, or dental appliance?**

_____

___ ___ **12. Do you have any missing or non-functioning organs such as testes, eye, kidney, etc.?**

_____

13. Menstrual History:

___ ___ Have you begun menses yet? _____

___ ___ **14. Do you have any other significant health problems?** _____

___ ___ **15. Hepatitis B Immunization Series?** _____

16. What is the date of your last tetanus immunization? _____

Parent/Guardian Signature: _____

PART III – PHYSICAL EXAMINATION

(To be completed and signed by examining physician)

Name: _____ School: _____

Height: _____ Weight: _____ Sex: _____ Age: _____ Grade: _____

Tanner Stage or Maturation Index: _____ Percent Body Fat: _____

BP: _____ Pulse at (rest): _____ (exercise): _____ (recovery): _____

Vision: Corrected (L) _____ (R) _____ Both: _____

Uncorrected (L) _____ (R) _____ Both: _____

Audiogram: _____

Cervical spine/neck: _____ Eyes: _____

Back: _____ Shoulders: _____

Ears: _____ Nose: _____

Throat: _____ Teeth: _____

Skin: _____ Lymphatic: _____

Lungs: _____ Heart: _____

Abdomen: _____ Genitalia/hernia: _____

Peripheral pulses: _____ Knees/hips: _____

Arm/elbow/wrist/hand: _____ Ankles/feet: _____

Lab:
Urine: _____

Hemoglobin or HCT: _____

And/or Fe stores: _____ ***WHEN MEDICALLY INDICATED**

I have read and reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics:

_____ Full Participation _____ Limited Participation

_____ No Participation _____ Needs Additional Evaluation

If not full participation, give reasons and recommendations: _____

_____

Any recommendations or concerns on such items as:

A. Weight loss or restrictions of weight loss: _____

_____

B. Slow and careful monitoring of conditioning because of being overweight or show an abnormal exercise testing? _____

_____

C. Other: _____

Physician Signature: _____, M.D.* Date: _____
***Doctor of Medicine, Doctor of Osteopathy or Licensed Nurse Practitioner**

Physician Name (Print): _____

Address: _____ City/Zip Code: _____

Telephone Number: _____

PART IV – ACKNOWLEDGEMENT OF RISK AND INSURANCE STATEMENT

(To be completed and signed by parent/guardian)

*I give permission for _____ (name of participant) to participate in the following sport (identify sport), _____.

*I have reviewed this examination form and I am aware that with the participation in sports comes the risk of injury to my child. I understand that the degree of danger and the seriousness of the risk vary significantly from on sport to another with contact sports carrying the higher risk. I have had an opportunity to understand the risk inherent in sports through meetings, written handouts, or some other means. He/she has student accident insurance available through the school, yes ___ no ___, has athletic participation insurance coverage through the school, yes ___ no ___, is insured by our family policy with:

Name of Company: _____

Policy Number: _____ Name of Policy Holder: _____

*I am aware that participating in sports will involve travel with the team. I acknowledge and accept the risks inherent in the sport and with the travel involved and with this knowledge in mind, grant permission for my child/ward to participate in the sport and travel with the team.

*I give my consent and approval for my child/ward to receive a physical examination, as required in Part III, Physical Examination, of this form, by _____ M.D., D.O., or LNP as recommended by the Town of Farmville Recreation Department.

Parent/Guardian Signature: _____ Date: _____

PART V – EMERGENCY PERMISSION FORM

(To be completed and signed by parent/guardian)

Participant's Name: _____ Grade: _____ Age: _____

School: _____ County: _____

Please list any significant health problems that might be significant to a physician evaluating your child in case of an emergency: _____

Please list any allergies to medications, etc.: _____

Has student been prescribed an inhaler or epipen? _____

Is student presently taking medication? If so, what type? _____

Does student wear contact lenses? _____

Please list the date of the participants last tetanus shot: _____

EMERGENCY AUTHORIZATION: In the event I cannot be reached in an emergency, I hereby give permission to physicians selected by the coaches and staff of the Farmville Recreation Department to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for the person named above.

Daytime Phone #: _____ Evening Phone #: _____

Parent/Guardian Signature: _____ Date: _____

Relationship to Participant: _____

*Emergency Permission Form may be reproduced to travel with respective teams and is acceptable for emergency treatment if needed.

I certify all the above information is correct: _____

(Parent/Guardian Signature)

******Providing false information will result in ineligibility for one year******