

# Trinity School at Meadow View

## Athletic Consent and Release Form 2011-2012

I, \_\_\_\_\_, grant permission for \_\_\_\_\_ to participate in Trinity School athletic events during the school year. In the event of an emergency, I authorize his/her coach or adult supervisors to act on my behalf in providing, arranging and consenting to medical care. I understand that Trinity School does not provide medical insurance coverage for students. Therefore, I assume responsibility for any medical expense, personal injury or other loss sustained by my son/daughter, and I agree to hold harmless and indemnify Trinity School and all its employees, sponsors, and volunteers, waiving all claims against said school from any such loss or liability.

**Insurance Company** \_\_\_\_\_  
Policy # \_\_\_\_\_

Does your child have any medical condition, which would prevent, restrict, or limit his/her participation in athletics? NO YES (Circle One)

If you have answered YES to the preceding question, you must enclose a letter or report from your doctor stating his opinion that your child may participate. If there are any restrictions, the doctor must set forth the restrictions or limitations in writing.

### Emergency information

Allergies \_\_\_\_\_  
Family Physician \_\_\_\_\_ Phone # \_\_\_\_\_  
Parent's Name \_\_\_\_\_ His Daytime Phone # \_\_\_\_\_  
\_\_\_\_\_ Her Daytime Phone # \_\_\_\_\_  
Evening Phone # \_\_\_\_\_ Other Phone # \_\_\_\_\_  
Name of someone, other than parent/guardian, who may be contacted in case of an emergency: Name \_\_\_\_\_ Phone # \_\_\_\_\_

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

**All students who wish to play sports must have an annual physical on file at Trinity before a student can participate in a sport. Please have this completed by the start of the sports season.** If you have any questions, contact Rick Schoof, (703) 641-0201.

Business Office/Athletic Department fax: (703) 641-9220

Trinity School at Meadow View

Pre-Participation Physical Evaluation

History

Date \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_ Age \_\_\_\_ Date of Birth \_\_\_\_\_

Grade \_\_\_\_ Sport \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Personal physician \_\_\_\_\_

Name

Address

Dr. phone

Explain "Yes" answers below:

Yes

No

- 1. Have you ever been hospitalized, and/or had surgery?
Has a doctor ever denied or restricted your participation in sports for any reason?
2. Are you presently taking any medicines or pills?
3. Do you have trouble breathing, or do you cough or wheeze, during or after activity?
Do you or does anyone in your family, have asthma?
Do you have prescriptions for use of epinephrine, adrenalin, an inhaler, or other asthma medications?
4. Do you have any allergies (medicine, bees, other stinging insects, etc.)?
Do you have prescriptions for these allergies?
5. Have you ever passed out during or after exercise, or any other time?
Have you ever been dizzy during or after exercise?
Have you ever had chest pain or shortness of breath during or after exercise?
Do you tire more quickly than your friends during exercise?
Does anyone in your family have a heart problem?
Has a doctor ever ordered a test for your heart?
Have you ever had high blood pressure, high cholesterol, or a heart infection?
Have you ever been told that you have a heart murmur?
Have you ever had racing of your heart or skipped heartbeats?
Has anyone in your family died of heart problems or a sudden death before age 50?
Have you ever been told that you have Marfan Syndrome, or has anyone in your family?
6. Do you have any skin problems (itching, rashes, or acne)?
7. Have you ever had a head injury?
Have you ever been unconscious?
Have you ever been hit in the head, knocked out, had memory loss, numbness, tingling, weakness in the arms/legs?
Have you ever had a seizure?
Have you ever had a stinger, burner or pinched nerve?
8. Have you ever had heat or muscle cramps?
Have you ever been dizzy or passed out in the heat?
9. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?
10. Have you had any problems with your eyes or vision?
Do you wear glasses, contacts, or protective eyewear?
11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?
12. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?
13. Have you had any blood disorders, or anemia?
14. Have you had a medical problem or injury since your last evaluation?
15. When was your last tetanus shot?
When was your last measles immunization?
16. When was your first menstrual period?
How many menstrual periods have you had in the past year?

Please explain all "yes" answers: \_\_\_\_\_

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

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_

Trinity School at Meadow View, 2849 Meadow View Rd., Falls Church, VA 22042  
 School Phone: 703-876-1920 Athletics Phone: 703-641-0201 Fax: 703-641-9220

**Pre-Participation Physical Exam (to be completed by physician)**

**Physical Examination**

**Date:** \_\_\_\_\_

Name: \_\_\_\_\_ M/F Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ Pulse \_\_\_\_\_

Vision R 20/ \_\_\_\_ L 20/ \_\_\_\_ Corrected Y/N Pupils \_\_\_\_\_ Audiogram \_\_\_\_\_

| Complete | Limited |                  | Normal |   |   |   |   | Abnormal Findings |  |  |  |  | Initials |
|----------|---------|------------------|--------|---|---|---|---|-------------------|--|--|--|--|----------|
|          |         |                  | 1      | 2 | 3 | 4 | 5 |                   |  |  |  |  |          |
|          |         | Cardiopulmonary  |        |   |   |   |   |                   |  |  |  |  |          |
|          |         | Pulses           |        |   |   |   |   |                   |  |  |  |  |          |
|          |         | Heart            |        |   |   |   |   |                   |  |  |  |  |          |
|          |         | Lungs            |        |   |   |   |   |                   |  |  |  |  |          |
|          |         | Tanner Stage     | 1      | 2 | 3 | 4 | 5 |                   |  |  |  |  |          |
|          |         | Skin             |        |   |   |   |   |                   |  |  |  |  |          |
|          |         | Abdominal        |        |   |   |   |   |                   |  |  |  |  |          |
|          |         | Genitalia/hernia |        |   |   |   |   |                   |  |  |  |  |          |
|          |         | Musculoskeletal  |        |   |   |   |   |                   |  |  |  |  |          |
|          |         | Neck/Spine       |        |   |   |   |   |                   |  |  |  |  |          |
|          |         | Shoulder         |        |   |   |   |   |                   |  |  |  |  |          |
|          |         | Arm/Elbow        |        |   |   |   |   |                   |  |  |  |  |          |
|          |         | Wrist/Hand       |        |   |   |   |   |                   |  |  |  |  |          |
|          |         | Lymphatic        |        |   |   |   |   |                   |  |  |  |  |          |
|          |         | Back             |        |   |   |   |   |                   |  |  |  |  |          |
|          |         | Knee/Hip         |        |   |   |   |   |                   |  |  |  |  |          |
|          |         | Ankle/Feet       |        |   |   |   |   |                   |  |  |  |  |          |
|          |         | Eyes, Ears, Nose |        |   |   |   |   |                   |  |  |  |  |          |
|          |         | Other            |        |   |   |   |   |                   |  |  |  |  |          |

**Clearance:**

**Cleared to participate without restriction:**

Soccer \_\_\_ Lacrosse \_\_\_ Basketball \_\_\_ Volleyball \_\_\_ Cross Country \_\_\_ Track \_\_\_

**Cleared after completing evaluation/rehabilitation for:** \_\_\_\_\_

**Not cleared for:**

\_\_\_ Collision \_\_\_ Contact \_\_\_ Non-contact \_\_\_ Strenuous \_\_\_ Moderately strenuous \_\_\_ Non-strenuous

Due to: \_\_\_\_\_

Recommendation: \_\_\_\_\_

Name of physician \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_ Phone \_\_\_\_\_

Doctor's signature: \_\_\_\_\_