The Cambridge School

Athletics Participation Evaluation–History & Exam

This form is to be completed annually by the participating student and parent or guardian.
Submit original form to the Athletics Office. Parents should retain a copy for their records.

PART I: TO BE COMPLETED BY THE STUDENT AND PARENT/GUARDIAN

Name of Student	Date of Birth ☐ M ☐ F	Grade	Age

Check all sports that apply for the school year: ☐ Basketball ☐ Cross Country ☐ Flag Football ☐ Swim ☐ Track and Field ☐ Volleyball ☐ Weight Training ☐ Summer Sport Camps

Address	City	Zip Code

Name of Parent/Guardian	Contact Number

EXPLANATION OF SCREENING PHYSICAL. I realize that the medical evaluations performed are only screens in order to evaluate general health, to disclose existing problems, and to determine my son or daughter's dynamic ability to participate in a given sport so that obvious conditions which might be damaged or aggravated by competitive sports can be found, evaluated and treated so as to prevent further injury. This examination does not guarantee against injury.

Parent Initials ______ Student/Athlete Initials ______

AWARENESS OF RISK. Student and Parent: I am aware that playing/practicing sports can be a dangerous activity involving many risks of injury. I understand that the risks of participation include, but are not limited to, death, serious neck and spinal cord injuries that may result in complete or partial paralysis, brain damage, serious internal injury to virtually any internal organs, bones, joints, muscles, tendons, or any other aspect of the skeletal system, and serious injury or impairment to other aspects of my body, general health and well being. I understand that the risks of participation may result not only in serious injury, but in impairment of my future ability to earn a living, to engage in other business, social and recreational activities, and generally to enjoy a good life. Because of the dangers of participating in sports, I recognize the importance of following coach instructions regarding playing techniques, training, equipment and other team rules, etc. both in competition and practice and agree to obey such instructions.

Parent Initials ______ Student/Athlete Initials ______

PERMISSION FOR TREATMENT. I hereby grant permission to the team physicians and those professional personnel designated by The Cambridge School to treat my son or daughter in the event of any injury. In the event of a serious injury, if I am unable to give my consent at that time, this consent is to include any and all emergency procedures deemed necessary by the attending emergency personnel. I also understand that in the event of injury, every reasonable attempt will be made to contact me prior to securing medical treatment beyond basic first aid.

Parent Initials ______ Student/Athlete Initials ______

PERMISSION TO LIFT WEIGHTS. I hereby grant permission for my child to lift weights under the supervision of a dedicated coach or athletic staff member. I understand the potential risk for injury associated with weight lifting training. By initializing below, I acknowledge the same risk for injuries (listed above) pertains to weight training as well. I recognize the importance of following the direction of the coach, learning the proper lifting techniques, using only appropriate weight loads, and take full responsibility for any injury that may occur while using any weight equipment.

Parent Initials ______ Student/Athlete Initials ______

PROOF OF INSURANCE. In compliance with California Education Code 32221, I certify that there is in effect at this time insurance coverage for medical expenses resulting from bodily injury of at least $5,000 for my son or daughter, and that this coverage will remain in effect throughout the time that he or she participates in sports. I also give my permission for the above named student to participate in sports, including regularly scheduled trips by supervised school transportation.

Name of Insurance Carrier ______________________ Policy/Group # ______________ Parent Initials ______ Student/Athlete Initials ______

MEDIA RELEASE. I understand that my name, picture, and/or grade point average may be released to the media.

Parent Initials ______ Student/Athlete Initials ______

ATHLETIC HANDBOOK. I have reviewed and agree to abide by the guidelines/policies in the Athletic Handbook which is posted on school website. By signing below, I acknowledge that it is my responsibility to read and understand these rules and discuss them with my parent/guardian/athlete.

Parent Initials ______ Student/Athlete Initials ______

CIF CONCUSSION INFORMATION. I agree that the safety of the athletes always come first. I have read the CIF Concussion Information Sheet and am familiar with the signs and symptoms of a concussion. I understand and support the decision that any athlete suspected of suffering a serious head injury may be removed from a game or practice immediately and will not be allowed to return to activity until medically cleared.

Parent Initials ______ Student/Athlete Initials ______

ATHLETIC POLICY AGAINST HAZING. The Cambridge School strives to maintain a healthy athletic program in which all students feel safe, welcome and proud of the school and the athletic programs that they represent. I understand that hazing of any kind is not allowed on this campus and in the athletic program. This includes mental, verbal and physical acts. I further understand that it is my duty to report any acts of hazing that I see to a coach or administrator on campus. By signing below, I agree to uphold this District policy and understand that any violation will result in my immediate suspension from athletics and further disciplinary action as outlined in District policy and procedures.

Parent Initials ______ Student/Athlete Initials ______

ETHICS IN SPORTS POLICY. I accept and understand the Policy Statement, Code of Ethics, The Pillars and Principles of Pursuing Victory With Honor, and the Violations, Minimum Penalties, and Appeal Process of the CIF–San Diego Section ETHICS IN SPORTS Policy. I agree to abide by this policy while participating and/or spectating at CIFSDS athletic events regardless of contest site or jurisdiction.

Parent Initials ______ Student/Athlete Initials ______

I have read all of the above statements and understand them fully and agree/consent to their contents.

Name of Student (print)	Name of Parent/Guardian (print)
Signature of Student	Signature of Parent/Guardian

The Cambridge School

Athletics Participation Evaluation–Medical History

This form is to be completed annually for the participating student by the parent/guardian prior to a physician visit. Submit original form to the Athletics Office. Parents should retain a copy for their records.

PART II: TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN

Name of Student	Date of Birth ☐ M ☐ F	Grade	Age

Check all sports that apply for the school year: ☐ Basketball ☐ Cross Country ☐ Flag Football ☐ Swim ☐ Track and Field ☐ Volleyball ☐ Weight Training ☐ Summer Sport Camps

List all **over-the-counter (OTC) medicines and supplements** currently being taken by the student:

☐ **Yes, this student is allergic to**:

General Questions	Y	N
1. Has a doctor ever denied/restricted your participation in sports?		
2. Please identify any ongoing medical conditions: ☐ ADD/ADHD ☐ Anemia ☐ Asthma ☐ Diabetes ☐ Infections ☐ Other:		
3. Have you ever spent the night in the hospital?		
4. Have you ever had any surgery?		
5. Do you have any physical or mental impairment which may affect participation in athletics or may require accommodations?		
Heart Health Questions About You	**Y**	**N**
6. **During** or **after** exercise, have you ever: ☐ felt short of breath ☐ felt lightheaded ☐ nearly passed out ☐ passed out		
7. Have you ever had discomfort, pain tightness, or pressure in your chest during exercise?		
8. Does your heart ever race or skip beats (irregular beats) during exercise?		
9. Do you get more tired or short of breath more quickly than your friends during exercise?		
10. Has a doctor ever told you that you have any heart problems? If yes, check all that apply: ☐ High blood pressure ☐ High cholesterol ☐ Kawasaki disease ☐ Hear murmur ☐ Heart infection ☐ Other:		
11. Has a doctor ever ordered a test for your heart? (ECG/EKG/echocardiogram)		
12. Have you ever had an unexplained seizure?		
Heart Health Questions About Your Family	**Y**	**N**
13. Has any family member or relative died of heart problems or had an **unexpected or unexplained** sudden death before age fifty (i.e. drowning, car accident, sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
Bone and Joint Questions	**Y**	**N**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game?		
18. Have you ever had broken/fractured bones/dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been diagnosed or x-rayed for neck instability or atlantoaxial instability (Down syndrome or dwarfism)?		
22. Do you regularly use a brace, orthotics, or other assistive device?		

Bone and Joint Questions	Y	N
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become red, painful, swollen, feel warm?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
Medical Questions	**Y**	**N**
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain, a painful bulge, or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last 3 months?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused prolonged headaches, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit of falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Are you trying to or has anyone recommended that you gain or lose weight?		
48. Are you on a special diet or do you avoid certain types of foods?		
49. Are there any concerns that you would like to discuss with a doctor?		
Female Only Questions	**Y**	**N**
50. Have you ever had a menstrual period?		
51. How old were you when you had your first menstrual period?		
52. How many periods have you had in the last 12 months?		
Please attach dates and details of any YES answers to this form.		

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

Signature of Student Date

Signature of Parent/Guardian Date

The Cambridge School

Athletics Participation Evaluation–Physical Examination

This form is to be completed annually for the participating student by the physician.
Submit original form to the Athletics Office. Parents should retain a copy for their records.

PART III: TO BE COMPLETED BY THE STUDENT'S PHYSICIAN

Name of Student	Date of Birth ☐ M ☐ F	Grade	Age

PHYSICAL EXAMINATION

Height	**Weight**	**BMI**	**BP**	**Pulse**	**Vision** Right: 20/ Left: 20/	**Corrected:** ☐ Yes ☐ No

Medical Evaluation	**Normal**	**Abnormal Findings**
Appearance (to include general congenital/developmental deformities)		
Eyes/ears/nose/throat/pupils equal/hearing		
Lymph nodes		
Heart (auscultation standing, supine, +/- Valsalva, PMI)		
Pulses (simultaneous femoral and radial)		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin (HSV, lesions suggestive of MRSA, tinea corporis)		
Neurologic		
Musculoskeletal Evaluation	**Normal**	**Abnormal Findings**
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional (duck walk, single-leg hop, front squat)		

(Name of student) ______________________________ was examined by me on (date) ________________ for a pre-participation physical evaluation. I have reviewed the attached health history and the athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined below. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete and parents or guardians.

☐ Cleared for all sports and athletic activities **without restriction**.

☐ Cleared for all sports and athletic activities **without restriction with recommendations for further evaluation or treatment** for

____

☐ **Not cleared**: ☐ Pending further evaluation ☐ For any sports and athletic activities ☐ For certain sport: ________________

Reason and recommendations: ____

____

______________________________ Name of Physician (print)

______________________________ Phone

______________________________ Signature of Physician

______________________________ Date

______________________________ Physician's Office Stamp