VALLEY CHRISTIAN SCHOOL

1312 Second Street Southeast, Auburn, Washington 98002 / 253.833.3541 / Fax 253.833.4239

ATHLETIC REGISTRATION

Student Name	Age	Birth Date	Grade	❑ Male ❑ Female
Address	City, State Zip			
Parent or Guardian Name	Home Phone		Cell Phone	
Email Address			Work Phone	

Your student has chosen to participate in a school athletic/activity program. The programs involve some dangers. Accidents happen and risks of serious injury do exist. Your signature indicates that you have been advised of this information.

I hereby grant permission for my student to participate in all sports for the current school year.

Parent or Guardian Signature	Date

REQUEST FOR WAIVER OF ACCIDENT PLAN – INSURANCE INFORMATION

I understand that my student cannot participate in Valley Christian School athletic or activity programs unless he/she is covered by accident insurance or I, the parent/guardian, accept full responsibility for all accident coverage and hold the school and coaches harmless.

Please initial one or more of the following:

_____ I have insurance coverage and will continue to keep it in force throughout the interscholastic season(s).

The name of the insurance company providing coverage is _____.

_____ Please waive the requirement for accident insurance and allow my named student to participate. I accept full responsibility for the cost of treatment for any injury he/she may suffer while participating in the program.

Parent or Guardian Signature	Date

CONSENT TO MEDICAL CARE AND TREATMENT – EMERGENCY INFORMATION

In the event of any medical emergency involving the above named student, I, the undersigned, as his or her parent or legal guardian, hereby grant authority and consent to the staff of Valley Christian School to administer or arrange for reasonable medical care for my child in the event that I cannot be contacted in time by reasonable means. For a medical emergency I further consent and grant authority to a physician, nurse or other appropriate health care provider to render whatever emergency care they deem necessary.

Signature of Parent or Legal Guardian	Date
Printed Name of Parent or Legal Guardian	Relation to Student

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PREPARTICIPATION HISTORY AND PHYSICAL EXAMINATION

Name: _____ Birth Date: _____

Address: _____ City: _____ Zip: _____

Phone: _____

HISTORY

	Yes	No	
1 a.	___	___	Have you had any illness/injury recently, or do you have an illness/injury now?
b.	___	___	Do you have any chronic or recurrent illness?
c.	___	___	Have you ever had any injuries requiring treatment by a physician?
d.	___	___	Do you have any organ missing other than tonsils (appendix, kidney, etc.)?
2.	___	___	Are you presently taking ANY medications (including vitamin, aspiring, etc.)?
3.	___	___	Do you have ANY allergies (medicines, bees, foods, or other factors)?
4 a.	___	___	Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?
b.	___	___	Do you tire more easily or quickly than your friends during exercise?
c.	___	___	Have you ever had any problem with your blood pressure or your heart?
d.	___	___	Have any close relatives had heart problems, heart attack or sudden death before age 50?
5 a.	___	___	Have you ever had fainting, convulsions, seizures or severe dizziness?
b.	___	___	Do you have frequent headaches?
c.	___	___	Have you ever been “knocked out” or “passed out”?
d.	___	___	Have you ever had a neck or head injury?
6.	___	___	Have you ever had heat exhaustion, heat stroke, or heat cramps?
7.	___	___	Have you had asthma, or trouble breathing, or cough during or after exercise?
8 a.	___	___	Do you wear eyeglasses, contact lenses or protective eye wear?
b.	___	___	Have you had any problem with your eyes or vision?
9 a.	___	___	Have you ever had a knee injury?
b.	___	___	Have you ever had an ankle injury?
c.	___	___	Have you ever injured any other joint (shoulder, wrist, fingers, etc.)?
d.	___	___	Have you ever had a broken bone (fracture)?
10.	___	___	Have you any medical concerns about participating in track?

***** ATHLETE SHOULD NOT WRITE BELOW THIS LINE *****

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

_____

_____

_____

PHYSICAL EXAMINATION

Age: _____ Pulse: _____ Height: _____

Blood Pressure: _____ Weight: _____

	Normal	Abnormal	
1. Head	____	____	_____
2. Eyes (pupils)	____	____	_____
3. Teeth	____	____	_____
4. Chest	____	____	_____
5. Lungs	____	____	_____
6. Heart	____	____	_____
7. Abdomen	____	____	_____
8. Neurologic	____	____	_____
9. Skin	____	____	_____
10. Spine, Back	____	____	_____
11. Shoulders	____	____	_____
12. Arms	____	____	_____
13. Legs	____	____	_____

Assessment: ____ Full participation

____ Limited participation (describe limitations, restrictions):

_____

_____

____ Participation contraindicated (list reasons):

_____

_____

Recommendations (equipment, taping, rehabilitation, etc.):

_____

_____

EXAMINER'S SIGNATURE: _____

PRINT EXAMINER'S NAME _____

DATE: _____ EXAMINER'S PHONE : ( )_____