PRE-PARTICIPATION HIGH SCHOOL PHYSICAL EXAMINATION

Name____Address____

Home Phone___________________________ Emergency Phone _________________________Age _____________Grade_______________

Date of Birth _____________________Place of Birth ______________________________Sex _______________________

____ Name of Parent or Guardian

____ Physician Name

CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:

1. Drug Allergies: _________________________
2. Current Medications _________________________
3. Eye Injury/Disease
4. Ear Surgery
5. Mastoid Surgery
6. Frequent Sore Throat
7. Fainting or Dizzy Spells
8. Convulsiions
9. Rheumatic Fever
10. Heart Disease
11. Diabetes
12. High Blood Pressure
13. Eye Surgery
14. Chronic Cough
15. Asthma
16. Collapsed Lung
17. Lung Disease
18. Hepatiitis
19. Infectious Mono.
20. Peptic Ulcer
21. Appendectomy
22. Hernia
23. Hernia Repair
24. Kidney Trouble
25. Testicle Operation
26. Broken Bones ___________________________
27. Heat Illness
28. Last Menstrual Period: ___________________________
29. Back Problem
30. Severe Headaches
31. Head Injuries
32. Neck Injuries
33. Other Bone or Joint Injuries:________________ ____________________________

PHYSICIAN TO COMPLETE THIS PORTION

Physician comments on history items circled above:
____

Height: __________________ Weight: __________________ Eyes (R): _______________ (L):____________________

Blood Pressure: _______________________________ Pulse: _____________________________

Circle number if abnormal and explain below: ____
____

1. HEENT	4. Lung	7. Hernia	10. Pilonidal	13. Upper Extremities
2. Teeth	5. Heart	8. Genitalia	11. Lymph Glands	14. Lower Extremities
3. Chest	6. Abdomen	9. Skin	12. Back & Neck	

Physician comments on circled items: ____
____

THE ABOVE STUDENT IS PHYSICALLY ABLE TO PARTICIPATE IN THE SPORTS CHECK BELOW:

_____ All	_____Equestrian	_____ Pom-Pon	_____Tennis
_____ Baseball	_____Football	_____ Skiing	_____Track
_____ Basketball	_____Golf	_____ Soccer	_____ Volleyball
_____ Cheerleading	_____ Gymnastics	_____ Softball	_____ Wrestling
_____ Cross Country	_____ Hockey	_____ Swimming	

DATE:______________________ **SIGNED:**____
Physician's Signature

Physicals must be updated every year for the next school year on or after April 15.

Brighton Area Schools
STUDENT PARTICIPATION AND PARENTAL APPROVAL FORM

____
PLEASE PRINT (Last Name) (First Name) (Initial) (School/Grade)

DATE____/____/____DATE OF BIRTH____/____/____ PLACE OF BIRTH_______________________

This application to participate in athletics at the above school is voluntary on my part and is made with the understanding that I have never received money or merchandise in any amount or any emblematic award worth more that twenty-five ($25.00) for participating in athletic events, and that I have never competed under an assumed name.

SIGNATURE OF STUDENT____

PARENT'S OR GUARDIAN'S PERMISSION

I hereby give my consent for the above student to engage in physical education, intramural, and interscholastic athletics at the above school in M.H.S.A.A. approved sports and to accompany the team as a member on it's out-of-town trips. I also agree to reimburse the Athletic Department for equipment issued to my son/daughter should it become lost.

We also carry accident or health insurance with____
(If none, please indicate, Brighton Area Schools requires coverage through the school insurance if none available)

Signature of Parent or Guardian____

Address____
Street City Zip

WAIVER OF LIABILITY AND AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I/We hereby authorize the Superintendent of Brighton Area Schools, or his/her designee or any school principal, coach or sponsor in attendance at any Brighton Area Schools contest or event to select, secure and consent to necessary medical attention for my child resulting from injury, illness or accident requiring medical care while I/We are not in attendance. I/We hereby release Brighton Area Schools and such person from any and all liability on account of such selection or authorization and for any and all damages which may occur on account thereof.

DATE_____________________________ ____
Father or Mother or Guardian

___________________________________ ____
Emergency Phone/Contact Address

____
Home Phone Work Phone