School City of Mishawaka
1402 South Main Street
Mishawaka, IN 46544
(574) 254-4500 ● www.mishawaka.k12.in.us ● fax (574) 254-4585

JOHN YOUNG MIDDLE SCHOOL
ATHLETIC PHYSICAL EXAMINATION FORM AND APPLICATION FOR PARTICIPATION

For School Year _____

_____ _____ _____ _____
Student Last Name First Name Middle Initial Grade

_____ _____ Sex _____ _____
Age Date of Birth Male Female

This application to compete in interscholastic athletics is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations. I know and appreciate the risks and dangers involved not only in athletics generally, but in the particular sports in which I wish to participate, and that unanticipated and unexpected dangers may arise during my participation in high school athletics, and I assume all risks of injury to my person and property that may be sustained by me or by my parents in connection with or in any way related to my participation in middle school athletics.

_____ _____
Date Signature of Student

Parent or Guardian's Permission and Release

I hereby give my consent of the above named student to represent his or her school in the athletic activities except for those indicated on this form by the examining physician, provided that such athletic activities are approved by the State Association. I also give my consent for the student to accompany the school team on any of its local or out-of-town trips. Consent is also given to physicians, physical therapists, physician's assistant, nurses, or other persons trained in the rendering of First Aid for the conduction of the pre-participation screening exam for the evaluation and treatment of injuries sustained during participation.

We acknowledge that the participant knows and appreciates the risks and dangers involved in the above designated athletics and is assuming all risks of injury and damage incident to his/her participation in said athletics. We do herby release, discharge, and relinquish the demands, actions, and causes of actions of any sort of any injuries sustained by the participant for me/us, and any damages to the participant's and my/our property.

_____ _____
Typed or Printed Name of Parent/Guardian Signature of Parent/Guardian

_____ _____ _____
Address Phone Date

Student Medical History Section: ***to be completed by parent*** *or family physician*

Name of Student _____ Parent Name _____
Phone _____

Family Doctor's Name _____
(Circle one)

Yes	No	1. Has had injuries requiring medical attention.
Yes	No	2. Has had illness lasting more than a week.
Yes	No	3. Is currently under physician's care.
Yes	No	4. Currently takes medication
Yes	No	5. Wears glasses (contact lenses yes/no)
Yes	No	6. Has been in hospital (except for tonsillectomy).
Yes	No	7. Has had a surgical operation.
Yes	No	8. Do you know of any reason why the individual should not participate in sports?

Please explain yes to above questions _____
_____
_____

Yes	No	9. Has complete poliomyelitis immunization
Yes	No	10. Has had a dental check-up in the past six (6) months.
Yes	No	11. Most recent tetanus toxoid immunization (date)
Yes	No	12. List known allergies:

Parent or Physician signature _____

Physician's Certificate
to be completed annually by physician holding unlimited license to practice medicine

Name of Student _____ JOHN YOUNG MIDDLE SCHOOL
Significant past illness or injury _____
Grade _____ Age _____ Height _____ Weight _____ Blood Pressure _____

Examination

Vision	Satisfactory	Unsatisfactory	Not Examined
Hearing	Satisfactory	Unsatisfactory	Not Examined
Respiratory	Satisfactory	Unsatisfactory	Not Examined
Cardiovascular	Satisfactory	Unsatisfactory	Not Examined
Liver, Spleen	Satisfactory	Unsatisfactory	Not Examined
Kidney	Satisfactory	Unsatisfactory	Not Examined
Hernia, genitalia	Satisfactory	Unsatisfactory	Not Examined
Musculoskeletal	Satisfactory	Unsatisfactory	Not Examined
Skin	Satisfactory	Unsatisfactory	Not Examined
Neurological	Satisfactory	Unsatisfactory	Not Examined
Other ( )	Satisfactory	Unsatisfactory	Not Examined

I certify that I have examined this student as indicated and find him/her physically able to compete in supervised athletics not marked out below:

Boy's Sports: Cross Country, Football, Basketball, Wrestling, Track
Girl's Sports: Cross Country, Volleyball, Basketball, Cheerleading, Track

Weight loss permitted to make lower weight class in wrestling? Yes ___No ___
If yes, student may lose _____pounds.
Physician's Address _____
Physician's Phone _____
Date of Examination/Certification_____ Physician's Signature _____