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

# MIDDLE SCHOOL ATHLETIC PHYSICAL EXAMINATION FORM AND APPLICATION FOR PARTICIPATION

School Year _____
School _____

_____ _____
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 of 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 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 _____ 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_____ Signed _____