## Alpine School District Extra-Curricular Activities Pre-Participation Physical and Parental Consent Form

PLEASE FILL OUT THIS FORM IN BLUE OR BLACK INK ONLY. DO NOT FOLD.

Student Name:	G	ender:	м	F Age: School Year:
Sport(s):				Date of Birth: / / Grade Level: 9 10 11 12
	PARENT/GUARDIAN TELEPHONE NUM	RERS		INSURANCE INFORMATION
Name:	Home: (	)	-	Insurance Company:
Relationship:	Father (Work):	)		Name on Insurance Policy:
Address:	Mother (Work): (	)	-	Group Plan/Policy Number:
City/State/Zip:	Other: (	)	-	Physician/Primary Care Center:
Person (differen	t residence) to contact in case of emergency when parent/guardian ca	nnot be	reache	ed: Hospital Preference:
Name:	Home: (	)	•	Insurance required for participation. Sport insurance
Relationship:	Other:(	)	-	information can be obtained through main office.
Term of the Contract with	QUESTIC	NAIRE		
Yes No		Yes N	0	
[][] 2. [][] 3. [][] 4. [][] 4.	Do you have an ongoing or chronic illness? Have you ever been hospitalized overnight? Have you ever had surgery? Are you currently taking any prescription or nonprescription (overthe-counter) medications or pills or using an inhaler? Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? Have you ever had a rash or hives develop during or after exercise?	] [ ] ] [ ] ] [ ]	] 10. ] 11. ] 12.	
[ ] [ ] 5. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]	acne, warts, fungus, or blisters)? Have you ever had a head injury or concussion? Have you ever been knocked out, become unconscious, or lost your memory? Have you ever had a seizure? Do you have frequent or severe headaches? Have you ever had numbness or tingling in your arms, hands, legs, or feet? Have you ever had a stinger, burner, or pinched nerve? 'answers here:	. []	] 13 [] 14 15	Have you broken or fractured any bones or dislocated any joints? Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?  If yes, check appropriate box and explain below  [ ] Head
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licensed health-care practitioner and/or hospital to secure proper treatment or care, including ambulance transportation, hospitalization, anesthesia, surgery, or injections of medication for my child in the event said student should be injured or stricken ill while participating in an interscholastic activity sponsored by the above named school. It is hereby understood that the consent and authorization hereby given and granted are continuing, and are intended by me to extend throughout the current school year. It is further understood that any expenses incurred will be paid for by insurance or the parent of the student. Payment of the expense is not a school responsibility. I/We hereby give my/our consent for the above named student to compete in the Pleasant Grove High School approved sports below: \_Swimming Baseball Cross Country \_Football \_Soccer Baskethall **Drill Team** \_Golf Softball Tennis Volleyball /We acknowledge that he/she will engage in all activities related to the team including trying out, practicing, playing and travel. I/We realize that such activity involves the potential for injury which is inherent in all sports. I/We acknowledge that even with the best coaching, use of the most advanced protective equipment and strict observance of rules, injuries are still a possibility. On rare occasions these injuries can be so severe as to result in total disability, paralysis, quadriplegia or even death. I/We acknowledge that I/we have read and understand this warning. I/We hereby agree to exonerate and hold harmless the Alpine School District, its agents, servants, and employees, including coaches, athletic trainers, and all practitioners of the healing arts treating my son/daughter, from any and all liability, claims, causes of action or demands of any kind and nature whatsoever which may arise by or in connection with my son's/daughter's participation in any activities related to the sports indicated above. Signature of parent/guardian: Date: Signature of student: Date: FOR PHYSICIAN'S OFFICE USE ONLY Doctor's Office Address Information VITAL STATISTICS Height: Pulse Rate: Vision: Left: Right: \_ Weight: Blood Pressure: Corrected: []Yes [ ] No % Body Fat (Opt): Pupils: [ ] Equal [ ] Unequal Phone: NORMAL INITIALS\* ABNORMAL FINDINGS GENERAL MEDICAL [] Appearance [ ] Eyes/Ears/Nose/Throat [] Lymph Nodes 1 Heart [] Pulses [ ] Lungs [] Abdomen Genitalia (males only) [] [] Skin MUSCULOSKELETAL [ ] Neck 1 1 Back [ ] Shoulder/arm [ ] Elbow/forearm [ ] Wrist/hand Hip/Thigh [] 1 Knee [ ] Leg/Ankle 1 Foot \*Station-based examination of PHYSICIAN'S COMMENTS CLEARANCE [ ] Cleared [ ] Cleared with conditions (see comments) [ ] Not cleared (see comments) Signature of physician:

Date:

In case of emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the certified athletic trainer,