

# Walker Valley Athletic Training

## PARENT/GUARDIAN CONSENT FORM

Athlete's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

I hereby give my consent for the above named student-athlete to participate in interscholastic athletics at Walker Valley High School during the **2004-2005** school year. I give my permission for said student to travel on all athletic trips scheduled for his or her team. I understand that, occasionally, a coach may assign my child to ride to an athletic event with a selected adult driver in a privately owned vehicle. In granting this permission I assume full responsibility for any and all damages to person or property caused by my child.

I agree that if it is determine that my child needs medical or dental treatment while participating in athletics, I will be responsible for any such treatment determine to be necessary by a physician, dentist, athletic trainer, or emergency medical personnel. I give my permission and consent to the Athletic Trainer to care for and provide appropriate medical treatment for my son/daughter in the event of injury. I also grant my permission and consent to the Athletic Trainer to dispense non-prescription over-the-counter medications such as Tylenol, Ibuprofen, Motrin, Pepto Bismol, and other like medications to my son/daughter when appropriate or per written and/or oral standing orders from WVHS affiliated team of physicians or other qualified physicians.

**I UNDERSTAND THAT BY PARTICIPATING IN INTERSCHOLASTIC ATHLETICS, MY SON/DAUGHTER IS EXPOSING HIM/HERSELF TO THE RISK OF SERIOUS INJURY, INCLUDING PARALYSIS OR DEATH.**

I also understand that my son/daughter is expected to adhere firmly to all established policies of his/her coach, the Walker Valley Athletic Department, the Bradley County School District, and the TSSAA. I affirm that my child legitimately resides in the Walker Valley High School attendance or had legal school district permission to attend Walker Valley High School.

*Parent/Guardian Signature:* \_\_\_\_\_ *Date:* \_\_\_\_\_

*Student Signature:* \_\_\_\_\_

I. EMERGENCY TREATMENT

To All Parents:

Since the malpractice question has come to the forefront, many hospitals and doctors will not treat a child without parent's consent (unless a matter of life or death). It is requested that you complete the information below so that if your child requires a visit to the hospital while under the supervision of the school, this will allow the hospital to treat the injury.

**EMERGENCY INFORMATION**

Name: \_\_\_\_\_ Sport: \_\_\_\_\_ Sex: M \_\_\_\_ F \_\_\_\_

Grade: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent's Name: \_\_\_\_\_

Father's SS#: \_\_\_\_\_ Mother's SS#: \_\_\_\_\_

Work Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Home Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Another Person to Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Insurance Name: \_\_\_\_\_

Policy and Group Numbers: \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

Consent Statement: Authorizing Treatment

Parent's Signature: \_\_\_\_\_

Student's Signature (if over age 18): \_\_\_\_\_

II. PARENT'S CONSENT

I hereby give my consent for \_\_\_\_\_ to represent  
(Name of Student)  
\_\_\_\_\_ in the sport of \_\_\_\_\_.  
(Name of School)

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**TMA/TSSAA PREPARTICIPATION MEDICAL EVALUATION FORM**

**Personal History**

Name	Sex	Age	DOB
Grade	Sport(s)		

School \_\_\_\_\_

Personal Physician	Address	Telephone
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Have you every had a preparticipation physical before?  Yes  No If yes, when/where \_\_\_\_\_

Please explain "Yes" answers below.

	Yes	No
1. Have you ever been hospitalized? Have you ever had surgery?	_____	_____
2. Are you presently taking any medications or pills?	_____	_____
3. Do you have allergies (medicine, bees or other stinging insects)?	_____	_____
4. Have you every passed out during exercise? Have you ever been dizzy during or after exercise? Have you ever had chest pain during exercise? Do you tire more quickly than your friends during exercise? Have you ever had high blood pressure? Have you ever been told that you have a heart murmur? Has anyone in your family died of heart problems or a sudden death before the age of 50?	_____	_____
5. Do you have any skin problems (itching, rashes, acne)?	_____	_____
6. Have you ever had a head injury? Have you ever been knocked unconscious? Have you ever had a seizure? Have you ever had a stinger, burner or pinched nerve?	_____	_____
7. Have you ever had heat or muscle cramps? Have you ever been dizzy or passed out in the heat?	_____	_____
8. Do you have trouble breathing or do you cough during or after activities?	_____	_____
9. Do you use any special equipment (pads, braces, neck role, mouth guard, eye guard)?	_____	_____
10. Have you had any problems with your eyes or vision? Do you wear glasses or contacts or protective eye wear?	_____	_____
11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling of any bones or joints? _____ Head      _____ Shoulder      _____ Thigh      _____ Neck      _____ Elbow _____ Knee      _____ Chest      _____ Forearm      _____ Shin/Calf      _____ Foot _____ Back      _____ Wrist      _____ Ankle      _____ Hip      _____ Hand	_____	_____
12. Have you ever had any other medical problem (infectious mononucleosis, diabetes)?	_____	_____
13. Have you ever had a medical problem since your last evaluation?	_____	_____
14. When was your last tetanus shot? _____ When was your last measles shot? _____		
15. When was your first menstrual period? _____ When was your last menstrual period? _____ When was the longest time between your periods last year? _____		

Please explain "yes" answers here:

I herby state that, to the best of my knowledge, my answers to the above questions are correct.

Signature of Athlete	Signature of Parent/Guardian	Date
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Signature of Coach	School	
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**General Physical Education**

Examiner: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ Pulse \_\_\_\_\_

Vision R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected? \_\_\_\_ Yes \_\_\_\_ No Pupils \_\_\_\_\_

	Normal	Abnormal Findings
Ears, Nose, Throat	_____	_____
Heart	_____	_____
Chest/Lungs	_____	_____
Skin/Lymphatic	_____	_____
Abdominal	_____	_____
Genitalia/Hernia	_____	_____

**Musculoskeletal Examination**

Examiner: \_\_\_\_\_

	Normal	Abnormal Findings
Neck/Back	_____	_____
Upper Extremities	_____	_____
Lower Extremities	_____	_____
Flexibility	_____	_____

**Optional Lab**  
 Urine Sugar \_\_\_\_\_  
 Urine Protein \_\_\_\_\_  
 Urine Hematest \_\_\_\_\_

**Official Recommendation**

- A. This athlete \_\_\_\_\_ may \_\_\_\_\_ may not compete in athletics based on the data gathered from this exam.
- B. Prior to participation, treatment or follow-up on the following is recommended:

C. Recommend further consultation with \_\_\_\_\_

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_