

DEARBORN PUBLIC SCHOOLS ATHLETIC PHYSICAL FORM
(Physician Form)

Name of Student _____
Last First Initial

Head, ears, eyes, nose and throat _____

Lungs _____

Heart _____

Abdomen _____

G.U. _____

Hernia _____

Extremities _____

BP _____ Pulse _____ Respiration _____ Height _____ Weight _____

The above named student is physically able to compete in supervised activities except those listed below.

Date

Physician's Signature

Phone number

DEARBORN PUBLIC SCHOOLS
ATHLETIC RESPONSIBILITY AND CONSENT FORM

Student's Name _____
Last First Initial

Student Number _____ Health Insurance Carrier _____

Home Address _____ Phone _____

City _____ Zip _____ Birth date _____ Grade _____

CONSENT TO PARTICIPATE IN ATHLETICS

I hereby give my consent for my child to participate in interscholastic athletics in the Dearborn Public Schools in approved sports during the current school year and for the disclosure to the Dearborn Public Schools of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics. I am satisfied with my health insurance coverage for participation in the interscholastic athletic program. We accept full responsibility for any injuries which might occur to our son or daughter by reason of such participation, including medical bills which might arise in excess of any insurance coverage, and we are fully apprised of the school district's position that neither it nor any person associated with the school athletic departments is liable under the law for such injuries. Further, I understand that neither the District nor any person associated with the school athletic department accepts responsibility for such injuries, and that costs related to such injuries, and that costs related to such injuries will not be paid from the operating funds of the school district.

WARNING – Participation in supervised interscholastic athletics and activities may be one of the least hazardous activities in which any student will engage in or out of school. PARTICIPATION IN INTERSCHOLASTIC ATHLETICS INCLUDES A RISK OF INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG TERM CATASTROPHIC. Although serious injuries are not common in supervised school athletic programs, it is impossible to eliminate this risk. Participants can and have the responsibility to help reduce the chance of injury. PLAYERS MUST OBEY ALL SAFETY RULES, REPORT ALL PHYSICAL PROBLEMS TO THEIR COACHES, FOLLOW A PROPER CONDITIONING PROGRAM AND INSPECT THEIR EQUIPMENT DAILY.

By signing this Permission Form, we acknowledge that we have read and understood this warning. PARENTS AND STUDENTS WHO DO NOT WISH TO ACCEPT THE RISKS DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS PERMISSION FORM.

STATEMENT OF POLICY

In compliance with Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Americans with Disabilities Act of 1990, it is the policy of the Dearborn School District that no person shall, on the basis of race, color, religion, national origin or ancestry, gender, age, disability, height, weight, or marital status, be excluded from participation in, be denied benefits of, or be subject to discrimination during any activity or in employment. For information, contact (313) 827-3113.

ATHLETIC CODE

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 of the Michigan High School Athletic Association, Inc. and that I will follow all rules and regulations set down by my coach and the athletic department. Also, as a representative of my school I will conduct myself in an exemplary manner at all times. I understand that conduct unbecoming of a team member or violation of the previously mentioned rules and regulation may lead to my dismissal from that team. **We (parent and child) have read, understand, and accept the rules of “The Athletic Code of Conduct”.**

ALCOHOL, TOBACCO, DRUGS & PERFORMANCE ENHANCING DRUGS

As a student-athlete, I understand and acknowledge that it is illegal to use alcohol, tobacco, drugs and/or performance enhancing drugs. I further understand that Dearborn Public Schools does not support the use of any of these substances and prohibits coaches from promoting such substances. If I violate this section of the physical form, I understand that the athletic director and/or administrator may take any disciplinary action necessary in order to comply with the student code of conduct and the laws of the State of Michigan.

_____ **Student Initials**

CONSENT FOR TRANSPORTATION

This is to certify that my child has my permission to make all trips to games, contests and tournaments during the current school year with the Dearborn Public Schools athletic teams. I understand that transportation will be by bus when practical and possible. Squad size and type of contest may necessitate transportation by van or driven by a licensed adult driver.

N.C.A.A. Rule 14.3 COLLEGE FRESHMAN ELIGIBILITY CLEARINGHOUSE REQUIRMENTS

All students and parents/guardians should be aware that student athletes that hope to compete at the collegiate level (Division I or II) must complete forms and pass criteria set forth by the NCAA Clearinghouse in order to have collegiate athletic eligibility. Graduating from high school or maintain good grades does not constitute automatic collegiate athletic eligibility. Students are urged to consult with their high school counselor as early in their prep career as possible to explore their NCAA Clearinghouse standing.

Address inquiries to: NCAA Clearinghouse
301 ACT Drive
P.O. Box 4043
Iowa City, IA 52243-4043
1-877-262-1492
www.ncaa.clearinghouse.net/ncaa/NCAA/common

EQUIPMENT FINANCIAL RESPONSIBILITY

Each athlete in the Dearborn Public Schools is responsible for athletic equipment issued to him/her by the athletic department. This equipment is to be worn only for practice or competition in the sport for which it was issued. It is not to be worn at other times. This equipment represents a large expenditure of money by the Athletic Department and is to be returned to the coach upon completion of the sport season (within one week). If equipment is stolen, lost or not returned the athlete will be held responsible for the replacement cost of the equipment.

We have read and understood all of the above statements and by our signatures indicate our willingness to abide by them.

Date **Student’s Signature**

Date **Parent’s/Guardian’s Signature**

Father’s Name _____ Mother’s Name _____

Father’s Work Phone _____ Mother’s Work Phone _____

Emergency Phone _____

Relationship of person with emergency phone number _____

Medical History Form for Student Athlete (Parent Form)

Answer all questions. Note any details Please.

	YES	NO		YES	NO
I. Head, ears, eyes, nose, throat			V. General History of:		
1. Do you wear glasses while playing?	<input type="checkbox"/>	<input type="checkbox"/>	1. Increased tiredness?	<input type="checkbox"/>	<input type="checkbox"/>
2. Any visual difficulties?	<input type="checkbox"/>	<input type="checkbox"/>	2. Bleeding disorders?	<input type="checkbox"/>	<input type="checkbox"/>
3. Frequent sore throats?	<input type="checkbox"/>	<input type="checkbox"/>	3. Family diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
4. Nose bleeds?	<input type="checkbox"/>	<input type="checkbox"/>	4. Family TB?	<input type="checkbox"/>	<input type="checkbox"/>
5. Decreased hearing?	<input type="checkbox"/>	<input type="checkbox"/>	5. Anemia?	<input type="checkbox"/>	<input type="checkbox"/>
6. History of being “knocked out”?	<input type="checkbox"/>	<input type="checkbox"/>	6. Tetanus immunization?	<input type="checkbox"/>	<input type="checkbox"/>
7. History of neck injury?	<input type="checkbox"/>	<input type="checkbox"/>	7. Weight loss?	<input type="checkbox"/>	<input type="checkbox"/>
8. History of seizures?	<input type="checkbox"/>	<input type="checkbox"/>	8. Infections?	<input type="checkbox"/>	<input type="checkbox"/>
II. Heart and Lungs			9. Allergies?	<input type="checkbox"/>	<input type="checkbox"/>
1. Shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	10. Medicine?	<input type="checkbox"/>	<input type="checkbox"/>
2. Frequent colds?	<input type="checkbox"/>	<input type="checkbox"/>	11. Drugs?	<input type="checkbox"/>	<input type="checkbox"/>
3. Chronic cough?	<input type="checkbox"/>	<input type="checkbox"/>	VI. Musculoskeletal History of:		
4. Rheumatic Fever?	<input type="checkbox"/>	<input type="checkbox"/>	1. Back or extremity surgery?	<input type="checkbox"/>	<input type="checkbox"/>
5. Heart Murmur?	<input type="checkbox"/>	<input type="checkbox"/>	2. Fractures?	<input type="checkbox"/>	<input type="checkbox"/>
6. Chest Pain?	<input type="checkbox"/>	<input type="checkbox"/>	3. Shoulder pain? Limited motion?	<input type="checkbox"/>	<input type="checkbox"/>
7. Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	4. Elbow injury?	<input type="checkbox"/>	<input type="checkbox"/>
III. Gastro Intestinal System			5. Back injury?	<input type="checkbox"/>	<input type="checkbox"/>
1. Constipation?	<input type="checkbox"/>	<input type="checkbox"/>	6. Ankle injury? Ankle swelling?	<input type="checkbox"/>	<input type="checkbox"/>
2. Abdominal Pain?	<input type="checkbox"/>	<input type="checkbox"/>	Ankle giving way?	<input type="checkbox"/>	<input type="checkbox"/>
3. Decreased appetite?	<input type="checkbox"/>	<input type="checkbox"/>	7. Knee injury? Knee pain?	<input type="checkbox"/>	<input type="checkbox"/>
4. Increased fluid intake?	<input type="checkbox"/>	<input type="checkbox"/>	Knee swelling?	<input type="checkbox"/>	<input type="checkbox"/>
5. Abdominal surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Knee giving way?	<input type="checkbox"/>	<input type="checkbox"/>
6. Nausea?	<input type="checkbox"/>	<input type="checkbox"/>	Knee clicking?	<input type="checkbox"/>	<input type="checkbox"/>
7. Vomiting?	<input type="checkbox"/>	<input type="checkbox"/>	Knee popping?	<input type="checkbox"/>	<input type="checkbox"/>
8. Diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>	Knee locking?	<input type="checkbox"/>	<input type="checkbox"/>
9. Blood in stool?	<input type="checkbox"/>	<input type="checkbox"/>			
10. Hemorrhoids?	<input type="checkbox"/>	<input type="checkbox"/>			
IV. Genito/Urinary System					
1. Urinary tract infection?	<input type="checkbox"/>	<input type="checkbox"/>			
2. Increased blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
3. Undescended testicles?	<input type="checkbox"/>	<input type="checkbox"/>			
4. History of venereal disease?	<input type="checkbox"/>	<input type="checkbox"/>			

Last visit to your family doctor and for what reason – Date _____ Reason _____

Parent/Guardian Signature _____ Date _____