VIRGINIA INDEPENDENT SCHOOLS ATHLETIC ASSOCIATION
344 Maple Ave W, #102, Vienna, Va. 22180

ATHLETIC PHYSICAL FORM

The Sports Medicine Advisory Committee recommends that member schools adopt this form as a best practice.
This form expires 14 months from the date of the practitioner's signature on page 3.

For school year_____ (To be filled in and signed by the student and parent/guardian)

PART I - ATHLETIC PARTICIPATION

Male___ Female___

Name _____ Student ID#_____
(Last) (First) (Middle Initial)

Home Address _____

City/Zip Code _____

Home Address of Parents _____

City/Zip Code _____

Date of Birth _____ Place of Birth _____

VISAA ELIGIBILITY RULES

To be eligible to represent your school in VISAA championship events or any regular-season competition in a sport in which your school has declared its intention to a participate in the VISAA championship, you must meet the requirements of Section 7 of the VISAA rules.

- You must be a regular bona fide student in good standing at the school you represent, taking an average of four hours of classroom instruction per day or at least five academic classes per semester/grade reporting period and working toward graduation requirements at the member school you represent.
- You must be enrolled and in attendance at the member school at least 30 days prior to the date of the start of the VISAA championship in that sport.
- You must not have reached the age of 19 on or before August 1 of the school year in which you wish to compete.
- You must be enrolled in grades eight through twelve.
- You must not have completed the graduation requirements of a school for any diploma category during the preceding academic year.
- You must not have been classified as a senior at any school during a preceding academic year.
- You must not have been ruled ineligible by your school's conference.
- You must be in compliance with VISAA amateurism rules.
- You must not receive financial aid based on athletic participation, and only receive aid in accordance with your school's regular financial aid policies.
- If you transferred from one VISAA memer school to another, then you are eligible to compete immediately in a varisty sport at your new school provided that you (a) are in good financial standing upon departure from the first school and you receive a statement of release of financial obligations from the first school, (b) have not engaged in competition in that sport during the current season at your first school, and (c) meet all other VISAA eligibility requirements.

Participation in interscholastic athletics is a privilege you earn by meeting not only the above-listed eligiblity standards, but also all other standards set by your conference and school. If you have any question regarding your eligibility or are in doubt about the effect an activity might have on your eligibility, **check with your school administration for interpretations of VISAA rules.** Meeting the intent and spirit of VISAA standards will prevent you, your team, school, and community from being penalized. Additionally, I give my consent and approval for my picture and name to be printed in any school or VISAA athletic program, publication or video.

→Student Signature: _____ Date:_____

→Parent/Guardian Signature: _____Date:_____

PROVIDING FALSE INFORMATION MAY RESULT IN INELIGIBILITY

PART II - ACKNOWLEDGEMENTS OF RISK AND INSURANCE STATEMENT

(To be completed by parent/guardian)

I give permission for _____ (name of child/ward) to participate in any of the following sports that are NOT crossed out: baseball, basketball, cheerleading, cross country, field hockey, football, golf, lacrosse, soccer, softball, swim/dive, tennis, track, volleyball, wrestling, other (identify sports): _____

I have reviewed the individual eligibility rules and I am aware that with participation in sports comes the risk of injury to my child/ward. I understand that the degree of danger and the seriousness of the risk varies significantly from one sport to another with contact sports carrying the higher risk. I have had an opportunity to understand the risk inherent in sports through meetings, written handouts or some other means. He/she has student medical/accident insurance available through the school (yes__ no__); has athletic participation insurance coverage through the school (yes__ no__); is insured by our family policy with:

Name of medical insurance company: _____

Policy number: _____ Name of policy holder: _____

I am aware that participating in sports will involve travel with the team. I acknowledge and accept the risks inherent in the sport and with the travel involved and with this knowledge in mind, grant permission for my child/ward to participate in the sport and travel with the team.

I hereby consent to allow the physician(s) and other health care provider(s) selected by me or the school to perform a pre-participation examination on my child and to provide treatment for any injury or condition resulting from participation in athletics for his/her school during the school year covered by this form. I further consent to allow said physician(s) or health care provider(s) to share appropriate information concerning my child that is relevant to participation in athletics with coaches and other school personnel as deemed necessary.

Additionally, I give my consent and approval for the above named student's picture and name to be printed in any high school or VISAA athletic program, publication or video.

To access quality, low-cost comprehensive health insurance through FAMIS for your child, please contact Cover Virginia by going to www.coverva.org or calling 855-242-8282.

PART III - EMERGENCY PERMISSION FORM*

(To be completed and signed by the parent/guardian)

STUDENT'S NAME: _____ GRADE: _____ AGE: _____ DOB: _____

HIGH SCHOOL: _____ CITY: _____

Please list and significant health problems that might be significant to a physician evaluating your child **in case of an emergency:**

_____

PLEASE LIST ANY ALLERGIES TO MEDICATIONS, ETC: _____

_____

IS THE STUDENT CURRENTLY PRESCRIBED AN INHALER OR EPI-PEN? _____ LIST THE EMERGENCY MEDICATION: _____
IS THE STUDENT PRESENTLY TAKING ANY OTHER MEDICATION? _____ IF SO, WHAT? _____
DOES THE STUDENT WEAR CONTACT LENSES? _____ DATE OF LAST Tdap OR Td (TETANUS) SHOT: _____

EMERGENCY AUTHORIZATION: In the event I cannot be reached in an emergency, I hereby give permission to physicians selected by the coaches and staff of _____ (school) to hospitalize, secure proper treatment for and to order the injection and/or anesthesia and/or surgery for the person named above.

WHERE TO REACH YOU IN AN EMERGENCY: Cell Phone_____ Other Phone_____

→ SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

RELATIONSHIP TO STUDENT: _____

*Emergency Permission Form may be reproduced to travel with respective teams and is acceptable for emergency treatment in needed.

→ I CERTIFY ALL OF THE ABOVE INFORMATION IS CORRECT: _____

Parent/Guardian signature

The pre-participation physical examination is not a substitute for a thorough annual examination by a student's primary care physician.

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Student's Name: _____ Date of Birth: _____

□ Medically eligible for all sports without restriction

□ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

□ Medically eligible for certain sports

_____

_____

□ Not medically eligible pending further evaluation

□ Not medically eligible for any sports

Recommendations:

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not h ave apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the p hysical examination findings are on record in my office and can be made available to the school at the request of the parents. If c onditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of heath care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional:_____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

Medications: _____

_____

Other Information: _____

_____

Emergency Contacts: _____

_____

_____

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Male: _____ Female: _____

Have you had COVID-19? (check one): Y N

Have you been immunized for COVID-19? (check one): Y N If yes, have you had: One shot Two shots Three shots Booster date(s) _____

List past and current medical conditions:_____

_____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). _____

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response)

	Not at all	*Several Days*	*Over half the days*	*Nearly every day*
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopless	0	1	2	3

(A sum of ≥ 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Unsure	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease? **Unsure**		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		

MENSTRUAL QUESTIONS	N/A	Yes	No
29. Have you ever had a menstrual period?			
30. How old were you when you had your first menstrual period?			
31. When was your most recent menstrual period?			
32. How many periods have you had in the past 12 months?			

Explain "Yes" answers here.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: _____ Weight: _____		
BP: / (/) Pulse: _____ Vision: R 20/ L 20/ Corrected: □ Y □ N		
COVID-19 VACCINE		
Previously received COVID-19 vaccine: □ Y □ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance		
Eyes, ears, nose, and throat		
Lymph nodes		
Heart[a]		
Lungs		
Abdomen		
Skin		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA