



Portsmouth Middle School League
P.O. Box 998, Portsmouth, VA 23705-0998

Athletic Participation/Parental Consent/Physician's Certificate Form
Separate form required for each school year (Good after May 1)

PART 1 - ATHLETIC PARTICIPATION (To be completed and signed by student)

Name: _____ School Year: _____
(Last) (First) (Middle Init.)

Home Address: _____

City and Zip Code: _____ Home Telephone: _____

Date of Birth: _____ Age: _____ Place of Birth: _____

I am in the 7th 8th grade at _____ Middle School

I have read the eligibility rules of the Portsmouth Middle School League that appear below and believe I am eligible to represent my school in the P.M.S.L.

Date: _____ Signed: _____

Individual Eligibility Rules

Attention Student! To be eligible to represent your school in the P.M.S.L. you must meet the following rules:

1. Be a bona fide full time student in good standing.
2. May not have reached the age of 15 on or before August 1st of the school year in which you intend to participate.
3. Satisfactorily complete a Portsmouth Middle School League Athletic Participation /Parental Consent/Physician's Form at least once each year.
4. May NOT participate during the days assigned to In-School Suspension.
5. May NOT participate for the remainder of the nine weeks season if the student receives two In-School Suspension assignments or one Out-of School Suspension within that season or length of time determined by the principal or designee.'
6. May participate in each activity only once as a seventh grader and once as an eighth grader or a total of two years.
7. These rules apply to ALL transfer students.
8. An eighth grader may participate on a junior varsity team at the high school they are zoned for if the seasons do not cross over.

Part 2 - Parental Consent

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

I have read the P.M.S.L. Individual Eligibility Rules listed above and I give my consent and approval to the participation of the student named above for the activities circled: TRACK, SOCCER, WRESTLING, VOLLEYBALL, BASKETBALL, TENNIS, SOFTBALL, FIELD HOCKEY, CROSS COUNTRY, FLAG FOOTBALL, OTHER.

Date: _____ Signed: _____

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 travel involved and with this knowledge in mind, grant permission of my child/ward to participate in the sport and travel with the team. I will not hold the school authorities responsible in case of accident or injury as a result of this participation. He/she has student accident insurance available through the school (yes ___ no ___) or is insured by our family policy with:

By this signature, I hereby consent to allow the physician(s) and other health care provider(s) selected by myself or the school to perform a pre-participation examination on my child and to provide treatment for any injury or condition resulting from participating in athletics/activities 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 and activities with coaches and other school personnel as deemed necessary.

Date: _____ Signature: _____
Parent/Guardian

Permission for Emergency Care

School _____ Year _____
Student's Name _____ Birthday _____ Homeroom _____
Parent's Name _____ Address _____
Home Telephone _____ Business Telephone _____
In case of emergency contact:
Name _____ Telephone _____
Relationship _____ Telephone _____
Family Physician _____ Telephone _____
Allergic to medicine (be specific) _____
Insurance in addition to athletics _____
Name of Company

In case of an emergency when my family physician or I cannot be reached, the school has my permission to take my child to the hospital emergency room and the hospital and its medical staff have my permission to provide treatment which a physician deems necessary for the well being of my child.

Parent's Signature _____ Date _____

PART III – MEDICAL HISTORY

This form must be completed by parent or guardian prior to the physical examination and should be taken with the physical examination form for review by the physician during the examination.

YES	NO	
___	___	1. Have you ever had any of the following Please explain any YES answers
___	___	heart murmur _____
___	___	high blood pressure _____
___	___	other heart problems _____
___	___	broken bones _____
___	___	weak joint-ankles, knees _____
___	___	concussion _____
___	___	operation _____
___	___	seizures or epilepsy _____
___	___	2. Have you ever fainted or passed out? _____
___	___	3. Have you ever been knocked out? _____
___	___	4. Have you ever been hospitalized? _____
___	___	5. Have you ever had to stop running after ¼ to ½
___	___	miles for chest pain or shortness of breath? _____
___	___	6. A. Have you ever had significant allergies to:
___	___	bee stings? – On medication – yes ___ no ___ _____
___	___	foods _____
___	___	medicine _____
___	___	others _____
___	___	B. Do you have prescription for use of:
___	___	Adrenaline _____
___	___	Inhalers _____
___	___	Other allergy medicine _____
___	___	C. Do you have asthma? _____
___	___	7. Do you take any medicine regularly? _____
___	___	8. Have you had any illnesses lasting a week or more
___	___	such as mononucleosis, etc.? _____
___	___	9. Have you had any blood disorders, including sickle
___	___	cell trait, anemia, etc? _____
___	___	10. Has any family member had a heart attack, heart
___	___	problems or sudden death before the age of 50? _____
___	___	11. Do you wear contact lenses, eyeglasses or dental
___	___	appliance? _____
___	___	12. Do you have any missing or non-functioning organs
___	___	such as testes, eye, kidney, etc.? _____
___	___	13. Menstrual History:
___	___	Have you begun menses yet? _____
___	___	14. Do you have any other significant health problems? _____
___	___	15. Hepatitis B Immunization Series? _____
___	___	16. DATE OF LAST TETNUS IMMUNIZATION? _____

Parent/Guardian Signature: _____

Part IV-PHYSICAL EXAMINATION
(To be completed and signed by examining physician)

NAME _____ SCHOOL _____

HEIGHT _____ WEIGHT _____ SEX _____ AGE _____

*Tanner Stage or Maturation Index _____	BP _____	
*Percent Body Fat _____	*Pulse (rest) _____	_____
	(Exercise) _____	_____
	(Recovery) _____	_____

*Vision: Corrected (L) _____ (R) _____ Both _____
 Uncorrected (L) _____ (R) _____ Both _____

* Audiogram: _____	Cervical spine/neck _____
Eyes _____	Back _____
Ears _____	Shoulders _____
Nose _____	Arm/elbow/wrist/hand _____
Throat _____	Knees/hips _____
Teeth _____	Ankles/feet _____
Skin _____	Lab: _____
Lymphatic _____	*Urine _____
Lungs _____	*Hemoglobin or HCT _____
Heart _____	and/or Fe Stores _____
Abdomen _____	
Genitalia/hernia _____	
Peripheral pulses _____	*WHEN MEDICALLY INDICATED

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics.

Full Participation Limited Participation
 No Participation Needs Additional Evaluation

If not full participation give reasons & recommendations: _____

Any recommendations or concerns on such items as:

- a. Weight loss or gain or restrictions of weight loss: _____
- b. Slow and careful monitoring of conditioning because of being overweight or show an abnormal exercise testing: _____
- c. Other _____

Physician Signature: _____, M.D.* Date _____

Physician Name (print) _____

Address: _____

City/Zip Code: _____

Telephone Number: _____