



CARLISLE

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Carlisle School
300 Carlisle Road, Axton VA 24054
P.O. Box 5388, Martinsville VA 24115

Athletic Participation/Parental Consent/Physical Examination Form Part I – Athletic Participation

School Year _____ Grade _____ Male _____ Female _____
Name: (Last) _____ (First) _____ (MI) _____
Home Address: _____
City/State/Zip: _____
Date of Birth: _____ Place of Birth: _____

Carlisle Sports Agreement

I am aware that playing in any sport can be a dangerous activity involving risks, including injury. As an athlete at Carlisle School, I understand that all of my actions while playing for Carlisle will impact the way people view my school. Therefore, I will do my best to play as hard as I can at all times while following the rules of the sports that I play. I will exhibit good sportsmanship at all times. I will not engage in unsportsmanlike behavior of any type, including trash talk, the use of profanity, taunting, etc. I will not be disrespectful to officials, coaches, spectators, teammates or opponents. I will refrain from using inappropriate language on and off the field. I will be gracious and humble in victory and defeat.

I agree to abide by the policies of Carlisle School. I understand that I am to wear representative dress each day my team is scheduled to play a game, even if I am unable to participate in the game. I understand that representative dress for boys includes a Carlisle logo polo shirt or blue, yellow or white dress shirt with a Carlisle School tie, dress slacks with plain or pleated front with a belt, darks socks and dress shoes. I understand that sneakers are not considered acceptable dress. I understand that representative dress for girls includes a skirt or dress slacks, a blue, yellow or white collared Carlisle logo blouse or polo shirt, collared knit shirt sweater and dress shoes with no higher than 2” heels. I understand that failure to wear representative dress on a game day and during travel to away games may result in my not being allowed to play or travel on that day.

I understand that I am responsible for returning all uniforms and equipment issued to me for each sport, and that failure to return these items will result in my being responsible for the cost of replacement. I understand that it is my responsibility to return uniforms and equipment to my coach within one week after the last game of the season.

I agree to abide by the above guidelines for Carlisle Athletics.

Student’s Signature: _____ Date: _____

Parent’s Signature: _____ Date: _____

I plan to participate in the following sports this year: ___ Soccer ___ Field Hockey ___ Volleyball ___ Cross County
___ Basketball ___ Softball ___ Golf ___ Fishing ___ Baseball ___ Tennis ___ Swimming

Permission to Travel

_____ My child has permission to travel to and from practices and games on school transportation (buses).

_____ My child has my permission to travel to and from practices and games with another parent.

_____ My child has my permission to travel to and from practices and games driving himself/herself.

_____ My child has my permission to travel to and from practices and games with another student driving.

Parent’s Signature _____ Date: _____

Part II – Medical History

This form must be completed by a 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 joints-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. Have you ever had significant allergies to:
_____	_____	Bee stings? _____ On medication? Yes _____ No _____
_____	_____	Foods _____
_____	_____	Medicine _____
_____	_____	Others _____
_____	_____	Do you have a prescription for use of:
_____	_____	Adrenaline _____
_____	_____	Inhalers _____
_____	_____	Other allergy medicine _____
_____	_____	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 appliances? _____
_____	_____	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 Tetanus Immunization? _____

Parent/Guardian Signature: _____

Part III – Physical Examination

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 and 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: _____ Date: _____

Physician Name: _____

Address/City/State/Zip: _____

Telephone Number: _____

Part IV – Insurance Statement

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, fishing, golf, gymnastics, lacrosse, soccer, softball, swimming/diving, tennis, track, volleyball, wrestling, other (identify sport).

I have reviewed the individual eligibility rules and I am aware that with the 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 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 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. With this knowledge in I grant permission for my child/ward to participate in the sport and travel with the team.

I also give my consent for my child/ward to receive a physical examination as required in Part III-Physical Examination, of this form, by _____ MD, OD or LNP as recommended by the name student’s school administration.

Additionally I give my consent for _____ (student) picture and name to be printed in any high school or athletic program, publication or video.

Parent Signature: _____

**Part V – Emergency Permission Form
(to be completed and signed by parent/guardian)**

Students Name: _____ Grade _____ Age _____

School Name: _____ City _____

Please list any health problems that might be significant to a physician evaluating your child in case of an emergency.

Please list any allergies to medications: _____

Has the student been prescribed an inhaler or epipen? _____

Is the student presently taking medications? _____ If so, what type? _____

Does the student wear contact lenses? _____ Please list the date of last 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 Carlisle School to hospitalize, and secure proper treatment for the person named above.

Daytime Phone Number (where to reach you in an emergency) _____

Evening Phone Number (where to reach you in an emergency) _____

Signature of parent or guardian _____ Date: _____

Relationship to student _____

*Emergency permission form may be reproduced to travel with respective teams and is acceptable for emergency treatment if needed.

I certify all the above information is correct: _____