HCPS
Henrico County Public Schools

HENRICO COUNTY PUBLIC SCHOOLS MIDDLE SCHOOL STUDENT PARTICIPATION, PARENTAL APPROVAL AND PHYSICAL EXAMINATION FORM

(TO BE COMPLETED BY PARENT/LEGAL CUSTODIAN, STUDENT AND PHYSICIAN)

VALID MAY 1 - JUNE 30 (14 MONTHS)

Student's Name _____ Birth date _____ Age _____
Grade _____ Sex M [ ] F [ ] Home Phone _____ Cell Phone _____
Parent/Legal Custodian's Name _____ Work Phone _____
Home Address of Student _____ School _____
Emergency Contact Person (other than parent/custodian) _____ Phone No. _____
Family Physician _____ Phone No. _____
Hospital preferred _____ ALLERGIES _____
MEDICATIONS (current) _____ Last Tetanus Booster Date _____

History of:

	(Circle)			(Circle)	
1. Any injuries requiring medical attention	Yes	No	5. Hospitalized (except for Tonsillectomy)	Yes	No
2. Under a physician's care at this time	Yes	No	6. Any chronic disease	Yes	No
3. Wears glasses or contact lenses	Yes	No	7. Any reason why this individual should not participate in competitive sports?	Yes	No
4. Surgery or operations					

If "Yes" to any of the above, list appropriate number explain _____

_____

In the event I cannot be reached in an emergency, I hereby give permission to physicians selected by the coaches and staff of _____ Middle School to hospitalize and/or secure proper treatment for the student named above.
I hereby consent to the above named student participating in the interscholastic athletic program at his/her school of attendance. This consent includes travel to and from athletic contests and practice sessions.

My child is covered by an insurance that meets my approval.
Company name _____ Policy Number _____
_____ My child is covered by 24 hour school insurance _____ My child is covered by School Day insurance.

PARENT/LEGAL GUARDIAN'S SIGNATURE _____ Date _____

This application to compete in interscholastic athletics for the above school is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the Board of Control for Middle School Athletics.

STUDENT SIGNATURE _____ Date _____

The proponent for this form is: DIVISION OF INSTRUCTION, Tel. 652-3761 Stock No. 1301-150 DISCARD ALL OTHER FORMS. REV. 8/27/01

Physical Examination
(To be completed and signed by examining physician)

Name of Student _____ School _____
Age _____ Height _____ Weight _____ B/P _____ P _____ R._____
Eyes _____ R20/ _____ L20/ _____ Ears _____ Hearing R _____ L _____
Cardiovascular _____
Respiratory _____
Liver _____ Spleen _____ Hernia _____
Musculoskeletal _____ Skin _____
Neurological _____ Genitalia _____

I certify that on this date I examined this student and on the basis of this examination, along with the medical history furnished to me, I found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities.

COMMENTS: _____

_____

_____

Physician's/Nurse Practitioner's Signature _____ Phone No. _____

Address _____

Date of Examination: _____

NOTE: THIS FORM MUST BE COMPLETELY FILLED OUT AND MUST BE FILED IN THE SCHOOL HEALTH OFFICE PRIOR TO THE STUDENT'S PARTICIPATION.