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, BASKETALL, 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			Please explain any YES answers
		1.	Have you ever had any of the following	
___	___		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 on 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:____________________

Eyes____________________
Ears____________________
Nose____________________
Throat____________________
Teeth____________________
Skin____________________
Lymphatic____________________
Lungs____________________
Heart____________________
Abdomen____________________
Genitalia/hernia
Peripheral pulses____________________

Cervical spine/neck____________________
Back____________________
Shoulders____________________
Arm/elbow/wrist/hand____________________
Knees/hips____________________
Ankles/feet____________________

Lab:
*Urine____________________
*Hemoglobin or HCT____________________
and/or Fe Stores____________________

***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:____________________