

**PRE-PARTICIPATION PHYSICAL EVALUATION  
FOR COLONEL JOHN WHEELER MIDDLE SCHOOL  
(BASED ON IHSAA FORM)**

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 \_\_\_\_\_  
 Sex: M F Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_  
 Personal Physician \_\_\_\_\_ Phone \_\_\_\_\_  
 Previous School Attended \_\_\_\_\_ Dates \_\_\_\_\_

Please answer the following:	Yes	No
1. Have you ever been hospitalized?		
2. Have you ever had surgery?		
3. Are you presently under a doctor's care?		
4. Do you have any allergies (medicine, bees or other stinging insects)?		
5. Have you ever passed out during or after exercise?		
6. Have you ever been dizzy during or after exercise?		
7. Have you ever had chest pains during or after exercise?		
8. Have you ever had high blood pressure?		
9. Have you ever had a heart murmur?		
10. Have you ever had racing of your heart or skipped heart beats?		
11. Has anyone in your family died of heart problems or a sudden death before age 50?		
12. Has anyone in your family had Marfan's Syndrome?		
13. Do you have any skin problems (itching, rashes, acne)?		
14. Have you ever had a head injury?		
15. Have you ever been knocked out or unconscious?		
16. Have you ever had a seizure or epilepsy?		
17. Have you ever had a stinger, burner or pinched nerve?		
18. Have you ever had heat cramps, heat illness or muscle cramps?		
19. Do you have trouble breathing or do you cough during or after activity?		
20. Do you use any special equipment (pads, braces, neck rolls, eye guards, etc)?		
21. Have you had any problems with your eyes or vision?		
22. Do you wear glasses or contacts or protective eye wear?		
23. Are you missing an eye, kidney, or testicle?		
24. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? Circle all that apply: Head Neck Shoulder Elbow Forearm Wrist Hand Back Hip Thigh Knee Shin/Calf Ankle Foot		
25. Have you had any other medical problems (mono, diabetes, anemia, etc)?		
26. Have you had a medical problem or injury since your last evaluation?		

Explain any "Yes" answers from above \_\_\_\_\_

27. When was your last tetanus shot? \_\_\_\_\_  
 28. When was your first menstrual period? \_\_\_\_\_  
 29. When was your last menstrual period? \_\_\_\_\_  
 30. What was the longest time between your periods last year? \_\_\_\_\_

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Signature of Athlete \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**Please turn form over for completion by physician.**

**PARENT/GUARDIAN  
CONSENT, ACKNOWLEDGEMENT AND RELEASE CERTIFICATE**

(To be completed by all parents/guardians whether divorced or separated, parent with legal custody must sign)

I/We hereby give consent for my son/daughter to participate in the following interschool sports **not marked out:**

**Boys' sports:** Basketball, Cross Country, Football, Track, Wrestling

**Girls' sports:** Basketball, Cross Country, Track, Volleyball

I/We understand that participation may necessitate an early dismissal from classes. I/We consent to the disclosure, by my son's/my daughter's school, to the IHSAA of all requested, detailed financial (athletic or otherwise), scholastic and attendance records of such school concerning my son/daughter. I/We know of and acknowledge that my son/daughter knows of the risks involved in athletic participation, understand that serious injury and even death, is possible in such participation and choose to accept any and all responsibility for his/her safety and welfare while participating in athletics. With full understanding of the risks involved, I/We release and hold harmless our school, the schools involved and the IHSAA of and from any and all responsibility and liability, including any and from their own negligence, for any injury or claim resulting from such athletic participation and agree to take no legal action against the IHSAA or the schools involved because of any accident or mishap involving my son's/my daughter's athletic participation. I/We consent to the exclusive jurisdiction and venue of the courts in Marion County, Indiana for all claims and disputes between and among the IHSAA and me and/or my child, including, but not limited to, any claims or disputes involving inquiry, eligibility or rule violation.

**Please check the appropriate space:**

- He/She has school student accident insurance
- He has football insurance through school
- He/She has adequate family insurance coverage
- He/She has no insurance and needs a waiver

**I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE PROVISION**

**Insurance Company** \_\_\_\_\_

**Policy Number** \_\_\_\_\_

**Parent/Guardian Name(s):**

\_\_\_\_\_

\_\_\_\_\_

**Parent/Guardian Signature(s):**

\_\_\_\_\_

\_\_\_\_\_

**Please complete emergency information on the other side.**

## EMERGENCY INFORMATION

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Gender: F M      Sport(s): \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

The Athletic Department is seeking your permission to have your son/daughter treated at a doctor's office or hospital emergency room in the event that he/she is found in need of emergency medical treatment. If an emergency occurs, every effort will be made to contact you. If such contact is not possible, this form may facilitate prompt medical treatment.

**I HEREBY GIVE MY PERMISSION FOR \_\_\_\_\_  
TO RECEIVE TREATMENT.**

**PARENT/GUARDIAN SIGNATURE \_\_\_\_\_**

**DATE: \_\_\_\_\_**