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Athletic Participation/Parental Consent/ Physical Examination Form

The following forms must be filled out and signed before a student is permitted to participate in any Lighthouse Baptist Academy sport practices or games. The forms include: *Athletic Participation, Acknowledgment of Risk and Insurance, Emergency Permission, Physical Examination, and Medical History*. All forms will expire on June 30th of the current school year. This includes the *Physical Examination Form* (part IV) which must be dated and signed by a qualified physician or physician's assistant. Physicals for the upcoming year must be performed after May 1st of the preceding school year.

PART I -- ATHLETIC PARTICIPATION

(To be filled in and signed by the student)

For School Year _____

Male _____
Female _____

Name _____ Social Security # _____
(Last) (First) (Middle Initial)

Home Address _____

City/Zip Code _____

Date of Birth _____ Place of Birth _____

Eligibility to participate in interscholastic athletics is a privilege. As a privilege, participation is governed by standards established by Lighthouse Baptist Academy and implemented by the school administrator, athletic director, and coaches. In addition to adhering to school stipulations, the administrative staff has high expectations that each athlete representing Lighthouse Baptist Academy in any sport, whether on the playing field/court or off, will lead the student body in Christian conduct, attitude, and behavior.

By signing below, the student indicated above promises to maintain the standards set forth by the athletic department of Lighthouse Baptist Academy.

Student Signature _____ Date _____

PART II -- ACKNOWLEDGMENT OF RISK AND INSURANCE STATEMENT

(To be completed and signed by parent/guardian)

I give permission for _____(name of student) to participate in any of the following sports: basketball, soccer, volleyball, golf (if available).

I have reviewed and understand the individual eligibility rules and I am aware that with participation in sports comes the risk of injury to my child. I understand that the degree of danger and the seriousness of the risk vary significantly from one sport to another with contact sports carrying a higher risk. I have had an opportunity to understand the risk inherent in sports through meetings, written handouts, or some other means. I understand that my child has student accident insurance available through the school, but further insurance is provided by our family policy:

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 involved. With this knowledge in mind, I grant permission for my child to participate in the sport and to travel with the team.

By this signature, I hereby consent to allow the physician(s) and other healthcare provider(s) selected by myself 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.

Additionally, I give my consent and approval for the above-named student's picture and name to be printed in any Lighthouse Baptist Academy publication, website, video, or printed athletic program.

Signature of parent or guardian _____

Relationship to student _____

Date _____

PART III - EMERGENCY PERMISSION FORM
(To be completed and signed by parent/guardian)

STUDENT'S NAME _____ GRADE _____ AGE _____

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, etc. _____

Has the student been prescribed an inhaler or epipen? _____

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

Does the student wear contact lenses? _____

Please list date of last tetanus shot _____

*EMERGENCY AUTHORIZATION: In the event of an emergency and I cannot be reached, I hereby give permission to physicians selected by the coaches and staff of Lighthouse Baptist Academy to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for the student named above.

Daytime phone number (where to reach you in an emergency) _____

Evening time phone number (where to reach you in an emergency) _____

Signature of parent or guardian _____

Relationship to student _____

Date _____

*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.

Parent/Guardian Signature

PART IV -- PHYSICAL EXAMINATION

(To be completed and signed by examining physician/physician's assistant)
(Physical examination form is required each school year dated after May 1st of the preceding school year
and is good through June 30th of the current school year)

NAME _____

HEIGHT _____ WEIGHT _____ SEX _____ AGE _____

*Tanner Stage or Maturation Index _____ BP _____

*Percent Body Fat _____ *Pulse: (rest) _____

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

*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 recommending 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 _____

*Doctor of Medicine, Doctor of Osteopathy, Physical Assistant, or Licensed Nurse Practitioner

Physician Name (print) _____

Address _____

City/Zip Code _____ Telephone Number _____

PART V -- MEDICAL HISTORY

(To be completed and signed by parent/guardian)

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 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. A. Have you ever had significant allergies to: |
| ___ | ___ | Bee Stings If so, are you on medication? yes___ no___ |
| ___ | ___ | Foods _____ |
| ___ | ___ | Medicine _____ |
| ___ | ___ | Others _____ |
| ___ | ___ | B. Do you have a 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 appliances? _____ |
| ___ | ___ | 12. Do you have any missing or non-functioning organs such as testes, eyes, kidneys, 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 _____

_____ Date