



STUDENT NAME

SEX

PHONE

D.O.B.

AGE

Please explain any "Yes" answer below: *(Include the number from the question and attach additional sheets if necessary.)*

Student/Athlete:

As a West Ottawa student athlete participating voluntarily in interscholastic athletics, I understand that:

1. I understand that I am expected to adhere firmly to all established athletic policies of my school district and the Michigan High School Athletic Association. I have read and will abide by the West Ottawa Athletic Handbook, Code of conduct, and the coach's team rules. **Copies of the Athletic Handbook are available at www.westottawa.net/athletics. You may also pick one up in the athletic office.**
2. I will be responsible for all athletic equipment issued to me throughout the season, will return such equipment at the conclusion of the season, and pay the current replacement cost for any equipment not accounted for by me at the end of the season.
3. I acknowledge that I have been properly advised, cautioned and warned by administrative or coaching personnel of the West Ottawa School District that I am exposing myself to the risk of injury, including but not limited to, the risk of sprains, fractures and ligament and/or cartilage damage which could result in temporary or permanent, partial or complete impairment in the use of my limbs, brain damage, paralysis; or even death. Having been so cautioned and warned, it is still my desire to participate in sports and to do so with full understanding of the risk of injury.

Student Signature: _____ Date: _____

Parent/Legal Guardian Consent/Assumption of Risk:

I, _____ hereby give permission for my son/daughter, _____

to undergo medical treatment for any injury or illness he/she may sustain or acquire while engaged in athletics with West Ottawa School District. I understand the medical personnel of West Ottawa School District, including athletic trainers and team physicians will perform only those procedures within their training, credentialing, and scope of professional practice to prevent, care for, and rehabilitate athletic injuries. In the event more serious medical treatment/procedures are required and I cannot be contacted for my consent, I authorize any licensed medical practitioner to perform such treatments/procedures medically necessary to alleviate the problem.

Participation in interscholastic athletics requires an acceptance of risk of injury. These risks include but are not limited to the following; death, quadriplegia, paraplegia, internal injury, closed head injury (possibly including post-concussion syndrome) and musculo-skeletal injuries (including sprains, strains, and fractures). Some of these injuries may result in medical treatment, surgery, and/or, permanent disability. I understand that coaches, athletic trainers, and physicians will use their professional judgment when applying appropriate medical treatment. I have had the opportunity to ask questions and hereby recognize the risk of injury and give my consent for my son/daughter to participate in interscholastic athletics at West Ottawa High School and for the disclosure to the MHSAA of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics.

Parent/Legal Guardian: _____ Date: _____



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THIS PORTION TO BE COMPLETED BY EXAMINING MEDICAL PRACTITIONER

Ht: _____ Wt: _____ B/P: R _____ L _____ Pulse: _____ Eyes: R _____ L _____

| Examination | Normal | Abnormal | Orthopedic | Normal | Abnormal |
|---|--------|----------|---------------|--------|----------|
| HEENT | | | Spine | | |
| Neck | | | Extremities | | |
| Lungs | | | Nervous | | |
| Heart: Supine | | | Shoulder | | |
| Heart: Standing or with Valsalva Maneuver | | | Pelvic Height | | |
| Abdomen | | | Knee Laxity | | |
| Hernia (males only) | | | Right | ACL | |
| Skin | | | | PCL | |
| Other: | | | | MCL | |
| | | | | LCL | |
| | | | Left | ACL | |
| | | | | PCL | |
| | | | | MCL | |
| | | | | LCL | |
| | | | Other: | | |

Therapist/Clinician: _____

Refer to Physician: _____ Athletic Trainer: _____

A CURRENT – YEAR PHYSICAL IS ONE GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR.

Physician's Statement

- 1. CLEARED WITHOUT RESTRICTIONS.
- 2. Cleared for LIMITED PARTICIPATION (specify): _____
- 3. NOT CLEARED for participation (explanation): _____
- 4. Requires further evaluation before final recommendation. _____

I certify that I have examined the above student-athlete and recommend him/her as being able to compete in supervised athletic activity as dictated by the clearance recommendations above.

Printed Name: _____

Date: _____

Signature: _____ MD, DO, PA, or NP