St. Thomas Aquinas Regional School

ATHLETIC PARTICIPATION/PARENTAL CONSENT/EVALUATION FORM

Physicals must be dated between May 1, 2025 and July 30, 2026

Pages 1-3 MUST be submitted to the school to be eligible for VHSL sports.

This form expires 14 months from the date of the practitioner's signature on page 3.

For school year_____

PART I- ATHLETIC PARTICIPATION

(To be filled in and signed by the student and parent/guardian)

Male ☐ Female ☐

PRINT CLEARLY

Name _____ Student ID#_____

(Last) (First) (Middle Initial)

Home Address _____

City/Zip Code _____

Home Address of Parents _____

City/Zip Code _____

Date of Birth _____ Place of Birth _____

INDIVIDUALIZED ELIGIBILITY RULES

ELIGIBILITY

A student may not participate in a sport if he/she turns fifteen (15) on or before September 1 of the current school year. A student may not participate in B (Junior Varsity) sports if the student is fourteen (14) years of age on or before September 1 of the current school year. Eighth graders may NOT participate in middle school B (Junior Varsity) sports. Sixth-grade students are allowed to participate in middle school varsity sports when, in the opinion of the coach, athletic coordinator, and principal, the student is mature enough and has the skills necessary to compete at the A (Varsity) level.

PARTICIPATION

A student may participate in only one school team during a given sports season and may change sports before the first competition. They may not change sport once the regular season begins. Any exception to this must be approved by the school's athletic coordinator and principal in the case of extenuating circumstances. Once a middle school student participates with a high school team, they forego the privilege to participate with the middle school team in that sport.

ACADEMIC ELIGIBILITY

A student must pass a minimum of five classes and fail no more than one class for the nine-week grading period. The student shall be declared ineligible for the next grading period. This rule applies to practice as well as game participation. Ineligible students who become eligible after team selections may not join a team.

MEDICAL EXAMINATION/PARENTAL PERMISSION

In all interscholastic activities, each participant must have a valid physical examination by a Doctor of Medicine, Doctor of Osteopathic Medicine, Nurse Practitioner or Physician's Assistant and have permission from parent/guardian before the participant may engage in any sport. An Emergency Care Card shall be completed by each participant and signed by the participant's parent/guardian. The cards shall be readily available to coaches at practices and games.

SELECTION OF TEAM

Team selection should include as many participants as possible. Each student trying out will receive information from their school specifying length of practice, criteria for squad selection, equipment needed, and a schedule of games. All squad selections will be implemented in a positive and objective manner. There will be three designated days for tryouts for all athletic teams.

INSURANCE

All students participating in the athletic program should have insurance coverage for accidents. The accident insurance policy made available by the Prince William County Public Schools covers all athletic activities.

LOCAL SCHOOL DIVISIONS AND VHSL DISTRICTS MAY REQUIRE ADDITIONAL STANDARDS TO THOSE LISTED ABOVE.

→Student Signature: _____ **Date:**_____

→Parent/Guardian Signature: _____ **Date:**_____

PROVIDING FALSE INFORMATION WILL RESULT IN INELIGIBILITY FOR ONE YEAR.

PART II- ACKNOWLEDGMENTS OF RISK AND INSURANCE STATEMENT

(To be completed by parent/guardian)

I give permission for _____ (name of child/ward) to participate in any of the following sports that are NOT crossed out: baseball, basketball, cheerleading, cross country, field hockey, football, golf, gymnastics, lacrosse, soccer, softball, swim/dive, tennis, track, volleyball, wrestling, other (identify sports): _____

I have reviewed the individual eligibility rules and I am aware that with the participation in sports comes the risk of injury to my child/ward. I understand that the degree of danger and the seriousness of the risk varies significantly from one sport to another with contact sports carrying the higher risk. I have had an opportunity to understand the risk inherent in sports through meetings, written handouts or some other means. He/she has student medical/accident insurance available through the school (yes☐ no☐; has athletic participation insurance coverage through the school (yes☐ no☐; is insured by our family policy with:
Name of medical insurance 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 and with this knowledge in mind, grant permission for my child/ward to participate in the sport and travel with the team.

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 participation in athletics/activities for his/her school during the school year covered by this form. I further consent to allow said physician(s) of 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 high school or VHSL athletic program, publication or video.

To access quality, low-cost comprehensive health insurance through FAMIS for your child, please contact Cover Virginia by going to www.coverva.org or calling 1-855-242-8282.

PART III- EMERGENCY PERMISSION FORM*

(To be completed and signed by the parent/guardian)

STUDENT'S NAME: _____ GRADE: _____ AGE: _____ DOB: _____

HIGH SCHOOL: _____ CITY: _____

Please list and significant health problems that might be significant to a physician evaluating your child **in case of an emergency:**

_____

PLEASE LIST ANY ALLERGIES TO MEDICATIONS, ETC: _____

_____

IS THE STUDENT CURRENT PRESCRIBED AN INHALER OR EPI-PEN? _____ LIST THE EMERGENCY MEDICATION: _____
IS THE STUDENT PRESENTLY TAKING ANY OTHER MEDICATION? _____ IF SO, WHAT? _____
DOES THE STUDENT WEAR CONTACT LENSES? _____ DATE OF LAST Tdap OR Td (TETANUS) SHOT: _____

EMERGENCY AUTHORIZATION: In the event I cannot be reached in an emergency, I hereby give permission to physicians selected by the coaches and staff of _____ High School to hospitalize, secure proper treatment for and to order the injection and/or anesthesia and/or surgery for the person named above.
DAYTIME PHONE NUMBER (WHERE TO REACH YOU IN AN EMERGENCY): _____

EVENING TIME PHONE NUMBER (WHERE TO REACH YOU IN AN EMERGENCY): _____

CELL PHONE NUMBER: _____

→ SIGNATURE OF PARENT/GUARDIAN: _____ **DATE:** _____

RELATIONSHIP TO STUDENT: _____

*Emergency Permission Form may be reproduced to travel with respective teams and is acceptable for emergency treatment in needed.

→ I CERTIFY ALL OF THE ABOVE INFORMATION IS CORRECT: _____

Parent/Guardian signature

The pre-participation physical examination is not a substitute for a thorough annual examination by a student's primary care physician.

The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

This form should be placed into the athlete's medical file and should *not* be shared with schools or sports organizations. The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another History Form.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, non-binary, or another gender): _____

Have you had COVID-19? (check one): ☐ Y ☐ N Vaccine not required for participation

Have you been immunized for COVID-19? (check one): ☐ Y ☐ N If yes, have you had: ☐ One shot ☐ Two shots ☐ Three shots ☐ Booster date(s) _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Unsure**	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		

MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease? **Unsure**		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		

MENSTRUAL QUESTIONS	N/A	Yes	No
29. Have you ever had a menstrual period?			
30. How old were you when you had your first menstrual period?			
31. When was your most recent menstrual period?			
32. How many periods have you had in the past 12 months?			

Explain "Yes" answers here.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

This form should be placed into the athlete's medical file and should *not* be shared with schools or sports organizations. The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another examination.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
COVID-19 VACCINE Not required		
Previously received COVID-19 vaccine: ☐ Y ☐ N Administered COVID-19 vaccine at this visit: ☐ Y ☐ N If yes: ☐ First dose ☐ Second dose ☐ Third dose ☐ Booster date(s) _____		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA