



# BAHRAIN SCHOOL ATHLETICS



Name: \_\_\_\_\_

Gender: M/F Grade: \_\_\_\_\_ Age: \_\_\_\_\_ Nationality: \_\_\_\_\_

Birthday: \_\_\_/\_\_\_/\_\_\_ CPR # \_\_\_\_\_

Passport # and Origin \_\_\_\_\_

Each player must have a CPR # for Island League games. Please provide this if your child has received a CPR#. If your child has not been issued a CPR#, then a valid passport number with country of origin will suffice. The athletic director will need a copy of these forms.

Mother's Email address: \_\_\_\_\_

Mother's Cell phone #: \_\_\_\_\_

Father's Email address: \_\_\_\_\_

Father's Cell phone #: \_\_\_\_\_

Alternate/Student Email: \_\_\_\_\_

## Uniform Responsibility:

(MIDDLE SCHOOL PROGRAMS ONLY) ----Each player will be required to purchase a team uniform for the season. It will be the player's responsibility to bring his/her clean uniform to all events as per the Coach's instruction. If the student athlete does not comply with the instruction, the player may be unable to participate in the event. (MIDDLE SCHOOL PROGRAMS ONLY)

## WhatsApp

The Bahrain School Sports teams will be using a free app called WhatsApp as the main source of getting information out to the teams. Please provide the best phone number and email for this purpose. If you do NOT wish to use WhatsApp, please check here \_\_\_

Email \_\_\_\_\_ Phone # \_\_\_\_\_

## Transportation Permission:

Often times, transportation must be provided by the coaches or player's parents to the Island League games that are at other schools. By signing below, you are granting your son/daughter permission to be driven to these games by coaches or other parents. If you do not sign, YOU must provide transportation (in these situations) for your child or he/she will not be able to attend the away games. This permission is effective until the end of the school year.

## POWER OF ATTORNEY

I grant permission for this child to participate in the MS Athletic Program. In the event that my dependent is injured or becomes ill, I authorize and release the Coach/Sponsor of this activity to take my dependent to a medical facility. I understand that I am responsible for all medical costs, to include ambulance service relating to my dependents injury or illness. The school, DoDDS and the US government bear no financial burden related to my dependents injury or illness with regard to participation in school activities.

I understand the coach/sponsor of this activity will use all diligent and responsible efforts to contact me or my spouse. If neither can be contacted after reasonable attempts, I authorize and release any physician or other qualified medical personnel to examine my child. I authorize any and all emergency care necessary for treating injuries or illness involving immediate danger to life or limb of my dependent. I further authorize and release any physician or other qualified medical personnel to administer non-emergency care necessary to treat minor injuries or illness of my dependent. I authorize basic first aide treatment necessary, not including major surgery or procedures involving substantial risk.

Signature of parent: \_\_\_\_\_ Date \_\_\_\_\_

# Athletic Physical Examination Form

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: M F

Grade: \_\_\_\_\_ School: \_\_\_\_\_ Sport: \_\_\_\_\_

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

Father's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Additional Emergency Contact Person (in the event neither parent can be reached):

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

## Medical History

	Yes	No		Yes	No
Any significant past injuries			Hospitalizations or surgeries		
Allergies, asthma, or wheezing			Seizures		
Contact lenses or glasses			Head injuries or concussions		
Currently on medication/medications			Bone or joint injuries		
Chronic illness			Current on all vaccinations		
Allergies			Other:		

Comments: \_\_\_\_\_

\_\_\_\_\_

## Physical Exam

	Result	Comments		Result	Comments
Ears			Neurological		
Nose			Genito-urinary		
Throat			Gastrointestinal		
Eyes			Spinal		
Skin			Mental Health		
Dental/Mouth			Cardiovascular		
Lungs			Musculoskeletal		

Final Diagnosis: \_\_\_\_\_

\_\_\_\_\_

I approve this student's participation in an interscholastic sport for one year.      Yes      No

Physician/PNP Name: \_\_\_\_\_

Physician/PNP Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Preparticipation Physical Evaluation HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam \_\_\_\_\_  
 Name \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies?  Yes  No If yes, please identify specific allergy below.

Medicines  Pollens  Food  Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below. <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply. <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_