



**GENERAL INFORMATION**

STUDENT NAME  
Please Print

STUDENT'S NAME \_\_\_\_\_  
(Last Name) (First Name) (Middle Initial)

PARENT/GUARDIAN \_\_\_\_\_  
(Last Name) (First Name)

PARENT/GUARDIAN \_\_\_\_\_  
(Last Name) (First Name)

HOME ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_

AGE \_\_\_\_\_ GRADE \_\_\_\_\_

**ANSWER ALL OF THE FOLLOWING QUESTIONS WITH YES OR NO:**

- \_\_\_\_\_ Are you currently living with your parent(s)?
  - \_\_\_\_\_ If no, are you living with your legal guardian?
  - \_\_\_\_\_ Are you currently living within the Wenatchee School District boundaries?
  - \_\_\_\_\_ Are you now or have you ever been a foreign exchange student?
  - \_\_\_\_\_ If yes, have you graduated from your equivalent school?
  - \_\_\_\_\_ Were you a transfer student last year?
- If yes, what was the date of your entrance to the Wenatchee School District? \_\_\_\_/\_\_\_\_/\_\_\_\_  
mo/day/year

- Do you attend: \_\_\_\_\_ Westside High School
- \_\_\_\_\_ Skill Source
  - \_\_\_\_\_ Skills Center
  - \_\_\_\_\_ Running Start
  - \_\_\_\_\_ Home School / River Academy
  - \_\_\_\_\_ Private School Private School Name \_\_\_\_\_

If you DID NOT attend Wenatchee Schools last year, what school did you attend:

Name of School \_\_\_\_\_ (Date Withdrew) \_\_\_\_\_

Location of School \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_

(Last)

(First)

(Middle Initial)

**Office Use:**

	<u>FALL</u>	<u>WINTER</u>	<u>SPRING</u>	<u>ALL YEAR</u>
ASB _____	FB _____	BBB _____	TR _____	SC _____
	VB _____	GBB _____	BA _____	CH _____
	GSO _____	WR _____	FP _____	AP _____
	GSW _____	BSW _____	GO _____	
	XC _____	GBO _____	TN _____	
			BSO _____	

**School Athletic Emergency Information/ Medical Clearance**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_

Home Address \_\_\_\_\_ Parent E-mail \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Contact Phone # \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Contact Phone # \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone # \_\_\_\_\_

**Insurance Company (Required) \_\_\_\_\_ Policy Number (Required) \_\_\_\_\_**

(If you do NOT have family medical insurance, you must purchase school insurance.)

School Insurance: \_\_\_\_\_ School Time Plan \_\_\_\_\_ Full Time Plan \_\_\_\_\_ Football Plan

**In the event of serious injury and your family doctor cannot be contacted, and if we are unable to contact one or the other parent/guardian, does the coaching staff/athletic trainer have your permission to seek medical attention from the nearest physician?**

\_\_\_\_\_ YES \_\_\_\_\_ NO If your answer is NO, please state procedure you wish the coaching staff/athletic trainer to follow:

I authorize release of the health care practitioner's (family physician and/or athletic physical provider) exam findings and other pertinent medical data as it relates to the participation of my child in Wenatchee School District sports activities. I understand that the physical exam documentation will be kept on file at their school for middle level athletes and in the Wenatchee High School Athletic Department for high school athletes. I understand it is my responsibility to make updates in the Athletic Office during the school year if my medical insurance changes.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**FALSIFYING SIGNATURES ON ANY REQUIRED FORM WILL BE CAUSE FOR LOSS OF ELIGIBILITY FOR ACTIVITY**

**PHYSICAL EXAMINATION** – Prior to the first practice for participation in interscholastic athletics, a student shall undergo a thorough medical examination and be approved for interscholastic athletic competition by a medical authority licensed to perform a physical examination.

Are there significant findings the school medical/coaching staff should be aware of:

- |   |  |
|---|--|
| _____ Head/neck/spine/injuries            | _____ Loss of paired organs                    |
| _____ Musculoskeletal injuries            | _____ Medications                              |
| _____ Cardiopulmonary conditions          | _____ Allergic to medicines/insect bites/other |
| _____ Other medical conditions (describe) |  |

Please explain any of the above: \_\_\_\_\_

**ASSESSMENT:**

\_\_\_\_\_ Full Participation

\_\_\_\_\_ Limited Participation (describe limitations. restrictions): \_\_\_\_\_

\_\_\_\_\_ Participation Contraindicated (list reasons and sports): \_\_\_\_\_

Recommendations (equipment, bracing, taping, rehabilitation, etc): \_\_\_\_\_

Those licensed to perform physical examinations include a Medical Doctor (MD), Doctor of Osteopathy (DO), Advanced Registered Nurse Practitioner (ARNP), Physician's Assistant (PA) and Naturopathic Physician.

\_\_\_\_\_  
**Date of Physical Exam**

\_\_\_\_\_  
**Examiner's Signature**

\_\_\_\_\_  
**Examiner's Name (Print)**