Moody AFB Youth Sports Instructional Class Registration Checklist

Ensure all items are completed before registration is submitted.

CHILD'S NAME: _____ AGE: _____

- ☐ SELECT SPORTS PROGRAM:
  - ☐ DANCE
  - ☐ KARATE/MARTIAL ARTS
- ☐ INSTRUCTIONAL CLASS CONTRACT:
  - ☐ Selected instructional class
  - ☐ Requested class day & time indicated
  - ☐ Instructional experience (optional)
  - ☐ Monthly fee explained
  - ☐ Date of physical _____ (DD/MMM/YY)
- ☐ COMPLETED FORM 88 (Air Force Youth Programs Registration)
  - ☐ Emergency contact MUST be someone other than parents/primary guardian.
  - ☐ Valid email address (Primary form of communication)
- ☐ DIVISION OF FAMILY & CHILD SERVICES (DHS) PACKET
  - ☐ Must be completed in its entirety before registration
- ☐ SPORTS PHYSICAL (must be current for the entire season)
  - ☐ Sports Physicals are good for one calendar year.
    [If date of physical date is May 15, 2016, physical form will expire May 15, 2017]
  - ☐ Copy of Sports Physical is due at time of registration – NO EXCEPTIONS!
  - ☐ Date of physical _____ (DD/MMM/YY)
- ☐ PAYMENT INFORMATION
  - ☐ Credit card auto-pay authorization – MUST HAVE ONE ON FILE
  - ☐ Instructional Payment Log
- ☐ PRIMARY PARENT TO CONTACT: Sponsor or Spouse
  - ☐ Name: _____
- ☐ ADDITIONAL EMAIL(S)

  _____
- ☐ **SPECIAL REQUESTS**

  _____

  _____

Youth Program Staff: Ensure that all items can be verified in the above checklist. Do not accept Registration Packet unless it is filled out in its entirety with all required documentation attached – NO EXCEPTIONS!

YP Staff's Name: _____ YP Staff's Initials: _____ Date: _____

MOODY AFB YOUTH PROGRAMS
INSTRUCTIONAL CLASS CONTRACT

PLEASE PRINT CLEARLY

CHILD'S NAME: (Last Name, Frist)		Sponsor's (Parent/Guardian) Name: (First Name, Last Name)
Class: (Karate or Dance)	Requested Class Day & Time:	Instructional Experience: (Years/Months)
Monthly Fee:		Physical Date: (Must remain current while youth is in the program) _____/_____/_____ (DD/MMM/YY) (Example: 09/MAR/97)

THE FOLLOWING STATEMENTS ARE IMPORTANT PROGRAM REQUIREMENTS/INFORMATION ITEMS. INITIAL ON THE LINE TO THE LEFT OF EACH ITEM TO INDICATE THAT YOU HAVE READ AND UNDERSTOOD EACH STATEMENT.

___1. PARENTAL SUPERVISION: All children under the age of 9 years old enrolled in an instructional class MUST have a parent/guardian or sibling (over the age of 16 years old) in the building at all times. **CHILDREN AGES 8 & UNDER CANNOT BE LEFT UNATTENDED AT ANY TIME!** For safety reasons, children may only be in the instructional room during their scheduled class time and with the guidance of an instructor. **Non-students may not be in the instructional classroom at any time. Parents and children are required to wait in the Multi-Purpose Room during class time.** Any items used from the bookshelves, must be return to its proper place.

___2. CLASS INSTRUCTORS: All Youth Center instructors are independent contractors and undergo local and national background checks and are required to attend annual training in accordance with AFI 34-249, Youth Programs. Each instructor is responsible for notifying students of their class schedules, which include monthly calendars and cancellations.

___3. CLASS FEES: Class fees must be paid in full no later than the 1st business day of each month. After the 3rd business day, payment will be automatically charged to the provided debt card on file. Student may be dropped from the class if timely payments are not made. Fees will **ONLY** be prorated due to initial enrollment in the during the month or class cancellation by the instructor or management, when makeup classes are not offered.

___4. CREDIT POLICY/AUTOMATIC PAYMENTS: In accordance with AFI 34-249, all participants in instructional classes are required to have a credit/debit card on file. If fees are not paid by the 1st business day of the month, payment will be automatically charged to the provided debt card on file, after the 3rd business day.

___5. CLASS FREQUENCY: Classes are conducted during the first four weeks of each month only. There will not be classes during the 5th week in months with five class weeks. All instructional classes offered are continuous in nature. Your child is enrolled in the class until you request in writing to remove your child from the class.

___6. CLASS CANCELLATION/MAKE-UP CLASSES: If a class is cancelled due to weather, power outage, instructor illness or emergency; classes will be rescheduled or class fees will be pro-rated. Make-up classes will be scheduled by class instructor and parents will be notified.

___7. SPORTS PHYSICALS: All students enrolled must have a current physical on file, prior to participation in any instructional classes

___8. MUTUAL CONTRACT OBLIGATIONS: Once a sponsor pays the monthly class fee and the instructor has taught the first class, a mutual contract obligation is in effect. Class payments are collected for a participant to have a slot in a class. Missed classes due to family commitments or similar circumstances will not be refunded or pro-rated. Refund requests will be accepted with proper documentation for illness, injury, or emergency leave lasting 2 weeks or more when accompanied by a doctor's statement or emergency leave orders and only if approved by the Youth Sports Director or the Youth Director In these cases, class positions will be held for a maximum of 2 months.

___9. VACATION/ANNUAL LEAVE: Class space will be held without charge for a maximum of 1 calendar month when the sponsor has completed a vacation request form **TWO WEEKS** prior to taking vacation/leave. If the student will be absent from class more than the allotted one month, the sponsor must pay for the additional absences to hold the student's position in the class. **Payment of the following month's class fee must be made prior to taking leave to avoid late fees.** It is the sponsor's responsibility to notify the instructor prior to the scheduled vacation time.

Reviewed/Revised 20 June 16

___10. TERMINATION POLICY: Should you decide to remove your child from a class a TWO WEEK WRITTEN NOTICE is required. Termination forms can be obtained at the Youth Center front desk.

___11. LIABILITY WAIVER/MEDICAL RELEASE: I desire for my child, _____, to participate in the sports programming to be offered by the Moody AFB Youth Sports Program, and be supervised by a volunteer coach and/or paid program staff members. I am allowing my child to participate in this sports program entirely upon my own initiative, risk and responsibility. I realize the risk of physical injury to my child as a result of his or her participation in this type of activity and have instructed my child to exercise caution for him or herself as well as for the other players, volunteers, parents, coaches, and staff. By giving permission for my child to participate in the sports programming, I release all liability from the individual coach, Moody AFB Youth (Sports) Programs, 23 FSS Squadron, Moody AFB, and the U.S. Government. I understand that none of the aforementioned parties can be held liable for any accident, injury, or death that may arise from any foreseen or unforeseen circumstances. By executing this release, I will assume complete responsibility for my child's actions or incidents occurring to him or her while involved in this activity. This release in no way limits or restricts medical care for those who are so entitled.

___12. LOSS OF PRIVILEGES: I/We further understand that any adverse behavior on the part of our child will result in the suspension of our privileges from this program.

___13. EVACUATION PROCEDURES: In the event of an evacuation (fire drills, fire alarms etc.) **everyone must leave the building.** Parents, staff, Youth Center visitors, and students are required to evacuate and assemble at the designated meeting locations. Students, in class, will evacuate with their instructors and remain with them until directed by appropriate personnel (Fire Department, Youth Center staff, etc.). Vehicles will not be allowed in or out of the parking lot until the Fire Department has given permission.

___14. ELECTRONIC AND PRINT PUBLICITY PERMISSION: I give consent for my child, _____, to be photographed and those photographs to be used for educational and marketing purposes at the Moody AFB Youth Center. I also give permission for my child's photo to appear in local and base papers, on the Moody AFB/Youth Center webpage, on the youth programs and the 23rd FSS' Facebook pages, on publicity displays throughout the installation and the youth center, used in other marketing and advertisements for Moody AFB Youth Programs and its various programs. Additionally, permission is granted to allow my child to be filmed and/or videotaped and have that footage featured on (those approved by military public affairs) news channels and other video marketing regarding the youth center and Moody AFB Youth Programs.

Parent/Guardian's Signature:	Date:
Youth Center Staff Signature:	Date:

AIR FORCE YOUTH PROGRAMS REGISTRATION

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 U.S.C. 8012 and 44 U.S.C. 3101.
PRINCIPLE PURPOSES: To register dependent youth of military, retired and DoD personnel in the Air Force Youth Programs. Providing Youth Programs the authorization for medical treatment in emergency situations; authorization for transportation; record youth/family information; photo use authorization; and releasing of liability.
ROUTINE USES: This form may be disclosed to any DoD component or part thereof, and upon request to other Federal, State and local government agencies in the pursuit of their official duties; disclosed to news media; used for other lawful purposes including law enforcement and litigation.
DISCLOSURE IS VOLUNTARY: Failure to provide the information may preclude the individual from participation in Air Force sponsored youth programs.

YOUTH NAME LAST, FIRST, MI	SPONSOR NAME / RANK LAST, FIRST	SPOUSE NAME / RANK LAST, FIRST	EMERGENCY CONTACT OTHER THAN PARENT
BIRTHDATE / AGE	ORGANIZATION	HOME ADDRESS	EMERGENCY PHONE SAME AS CONTACT
MALE / FEMALE	WORK PHONE	WORK PHONE	PHOTO PERMISSION YES / NO
YOUTH HOME EMAIL	CELL PHONE	CELL PHONE	SPONSOR WORK EMAIL
HOBBIES & INTERESTS	SPONSOR SS # (LAST 4)	HOME PHONE	PARENT VOLUNTEER YES / NO

SPECIAL NEEDS CARE / ILLNESS / ALLERGIES / INJURIES

RELEASE OF LIABILIITY AND AGREEMENTS

MEDICAL CARE AUTHORIZATION: I hereby authorize my child to receive emergency medical treatment whenever it is deemed necessary at any U.S. Military Facility or any other medical facility when a U.S. Military Medical Facility is not avaliable.
HOLD AND SAVE HARMLESS AGREEMENT: Now therefore, in consideration of mutual covenants and agreements between the parties here to it is agreed as follows: We the parents of the above named youth agree to save and hold harmless as well as defend the Base Youth Programs, Services Division's Central Base Fund, Department of the Air Force and the contractor from and against any and all claims, demands, actions, debts, liabilities and attorney's fees. Parent further agrees to save and hold harmless the contractor and all other parties involved from and on account of damages of any kind which the youth may suffer as a result of the acts of participating in the program.
TRANSPORTATION/FIELD TRIP: I give Youth Programs permission to transport the aboved named youth to and from any events that I am notified of in advance.

SIGNATURE OF PARENT/LEGAL GUARDIAN	DATE

FOR USE BY YOUTH PROGRAM STAFF (COMPLETE & INITIAL)

PROGRAM ORIENTATION DATE	MEMBERSHIP CARD ISSUE DATE	MEMBERSHIP CARD NUMBER
EXPIRATION DATE	MEMBERSHIP FEE PAID	STAFF INITIAL / DATE

Division of Family and Children Services
Afterschool Care Program
Youth Eligibility Form

Moody AFB Youth Programs, along with the Division of Family and Children Services (DFCS) are partnering to provide valuable and exciting out-of-school programs for youth in Georgia. The information provided on this form will help ensure that eligible youth are benefiting from the partnership. Please complete this form in its entirety and return it to the identified staff person at the program site. We thank you for your cooperation.

Form to be completed by Parent/Custodian/Caregiver

Youth Information – ***This section must be completed in its entirety.***

Name of Youth Participant (Last) _____ (First) _____ (MI) _____

Social Security Number _____ - _____ - _____ Gender: _____ Male _____ Female

Date of Birth (mm/dd/yy): ___ ___ /___ ___ /___ ___

Section 1

A. Is the youth applicant a U.S. citizen or qualified alien? ☐ Yes ☐ No
B. Is the youth applicant a Georgia resident? ☐ Yes ☐ No
C. Does the youth applicant fall into one (1) or more of the three categories below (Answer YES or NO and check all categories below that apply to the youth)?: ☐ Yes ☐ No
____Youth applicant is between the age of 5 and 17 years old; **OR**
____Youth applicant is 18 years old and currently enrolled in school *(high school, GED program or equivalent, or post secondary institution)* and will be enrolled in AND attend school during the upcoming academic year *(Verification of school enrollment includes a letter from the school on official school letterhead):* **OR**
____Youth applicant is 18 - 19 years old and has a dependent child AND is the custodial parent

If the one (1) or more answers to the questions in Section 1 is NO, the youth **IS NOT** eligible to participate in the DFCS funded services. **If the answer to ALL of the questions in Section 1 is YES**, please complete the remainder of the form.

Section 2

Does the youth currently receive benefits or services under any of the programs listed below (Please Note: you will have to provide official verification to the afterschool/summer program):

		Yes	No
A.	Temporary Assistance for Needy Families (TANF)	☐	☐
B.	Supplemental Nutrition Assistance Program (SNAP) *(also known as Food Stamps)*	☐	☐
C.	Medicaid or Social Security Income (SSI)	☐	☐
D.	Reduced or free lunch program at school	☐	☐
E.	Peachcare for Kids	☐	☐

If the answer to at least one question in section 2 is YES, the youth is eligible to participate in the program and the parent/custodian/guardian may complete Section 5. Verification for receipt of services checked in Section 2 must be provided and a copy of the verification must be attached to this eligibility form. If the program does not receive verification of items checked in Section 2, the youth will not be able to participate in the program.

If the answer to ALL of the questions in Section 2 is NO, the parent/custodian/guardian **MUST** complete Section 3, Section 4 and Section 5 for eligibility determination. Verification for items listed in Section 3 and Section 4 must be provided and a copy of the verification must be attached to this eligibility form.

Section 3

If you answered NO to ALL of the questions in Section 2, please review the chart below and enter your family unit size, gross household yearly income and gross household monthly income to determine eligibility.

Family Income Eligibility for the DFCS Afterschool Care Program Income Eligibility Guide

Number of Persons in Family Unit	Federal Poverty Level *	DFCS Afterschool Care Program Annual Household Income Guidelines **	DFCS Afterschool Care Program Monthly Household Income Guidelines
1	$11,670	$35,010	$2,918
2	$15,730	$47,190	$3,933
3	$19,790	$59,370	$4,948
4	$23,850	$71,550	$5,963
5	$27,910	$83,730	$6,978
6	$31,970	$95,910	$7,993
7	$36,030	$108,090	$9,008
8	$40,090	$120,270	$10,023
Each additional person, add	$4,060	$12,180	$1,015

* Income based on the Office of the Secretary, U.S. Department of Health and Human Services (HHS) 2014 Poverty Guidelines for the 48 Contiguous States and the District of Columbia. (Source: 79 FR 3593, Page 3593 – 3594, Document Number: 2014-01303)
** 300 % of the federal poverty level

Family Unit Size* _____
Gross Household Yearly Income $_____ Gross Household Monthly Income $_____

** See Appendix A for definition of family unit.*

Section 4

Please complete Section 4 by listing your name, the name of the child (ren) who live with you, and the other parent of the child (ren) if s/he lives with you. List any gross monthly income for each.

Household Composition and Income					
Gross Monthly Income is income before taxes and deductions.					
Name (First, Middle, and Last)	Relationship	Date of Birth (MM/DD/YY)	Income Source	Amount (Gross Monthly Income)	How often received?
	SELF				

Section 5

Please review and sign Section 5 as notification and signature of verification.

Applicant Notification and Signature

We are asking for your youth's Social Security number because any person applying for or receiving federal benefits must give us his or her Social Security number. Federal law 409(a) (4) of the Social Security Act and federal regulations (45 CFR 264.10) allow us to collect this information.

By signing this application,

- I swear, under penalty of perjury, that to the best of my knowledge, all the information and statements I've provided in this application are true, and
- I promise to cooperate with any effort to verify the information provided.
- If selected to participate in the program, I promise to abide by all rules and guidelines.

Parent/Guardian/Caregiver Information – *This section must be completed in its entirety.*

Name of Parent/Guardian/Caregiver (Last, First, MI) _____

Street Address _____ City _____ State _____ Zip Code _____

Home Phone # _____ Work # _____ Cell# _____

_____ _____

Parent/Caregiver/Guardian Printed Name Date

_____ _____

Parent/Caregiver/Guardian Signature Date

To be Completed by DFCS Funded Afterschool/Summer Service Provider

By signing below, I certify the information presented within this form was reviewed, verified and confirmed** and meets the DFCS Afterschool Care Program Eligibility rules and guidelines indicated within this form. I also certify this form will be kept in the youth participant's file in a confidential and secured location.

_____ _____ _____

Authorized Program Staff Signature Title Date

***** See Appendix B for income verification proof sources***

APPENDICES

*Appendix A: Family Unit

The Department of Human Services Temporary Assistance for Needy Families (TANF) definition of family includes the dependent child for whom assistance is requested and certain other individuals living in the home with the child who are required to be included in the family.

The following individuals are considered members of the Family Unit:

- A biological or adoptive parent of the dependent child for whom assistance is requested;
- An eligible minor sibling, (whole, half or adoptive) of the dependent child for whom assistance is requested;
- Other children living in the home who are within the specified degree of relationship to the grantee relative but who are not members of the Family Unit; and
- A non-parent relative who is the caretaker if there is no parent in the home or if the only parent in the home receives SSI.
- An individual documented as the youth's caregiver. A caregiver is considered a person who provides direct care to the youth. This provision includes foster parents.

**Appendix B: Income Proof Sources and Applicable Income Sources

Income verification must be obtained and a copy must be attached to the youth's income eligibility form.

Examples of earned income verification are:

- Pay stubs or receipts for the most recent four weeks of earnings;
- W-2 Forms;
- Employer's issued, signed and dated documentation;
- Personal income ledger or tablet (e.g. self-employed)
- Quarterly income tax returns;
- Annual income tax returns when presented in January – March quarter;
- Letter/statement from employer;
- Documentation from other DFCS staff such as the eligibility CM; and/or
- Form 809 or itemized statement completed by the employer.

Examples of unearned income verification are:

- Copy of current check with check stubs (within last 4 weeks);
- Award letters or written, signed and dated statement of payer;
- Social Security Records;
- Worker's compensation records;
- Form 139 – Contribution statement;
- Unemployment insurance claim records;
- SUCCESS screen information; and/or
- STARS.

See page 2 of Appendix B for applicable income sources.

Applicable Income

Each of the following sources of income is budgeted in determining eligibility:

Earned

- Wages or salary – Gross income of the applicant is used to determine eligibility
- Net Income from Self-Employment
- Employee commission
- Jury Duty
- Rental Income – (regular and ongoing payments – if engaged in management of property for an average of 20 hours or more per week)
- Roomer Income – (regular and ongoing payments)

Unearned

- Military Allotments
- Cash gifts Charitable gift exceeding $300 received from and organization receiving state or federal funds
- Inheritances
- Insurance Benefits due to Loss of Income – benefits paid from an insurance policy due to loss of income
- Social Security Benefits
- Unemployment Compensation
- Worker's Compensation
- Alimony – (regular and ongoing payments)
- Child Support – (regular and ongoing payments)
- Farm Allotment – payments received from government-sponsored programs, such as Agricultural Stabilization and Conservation Services
- Veteran's Benefits
- Capital Gains
- Interest/Annuity
- Capital Gains/Dividends
- Pension
- Trust Fund
- Disability Payment
- Boarder Income – (regular and ongoing payments)
- Rental Income – (regular and ongoing payments - if engaged in management of property for an average of 20 hours or less per week)
- Deferred compensation through retirement plan.

MOODY AFB YOUTH PROGRAMS

Credit Card Auto-Pay Authorization

Type of Card:

☐ VISA ☐ MASTERCARD

Credit Card Number:

☐☐☐☐ | ☐☐☐☐ | ☐☐☐☐ | ☐☐☐☐

Expiration Date (MM/YY):

☐☐ | ☐☐

Cardholder Name (as it appears on the card):

_____

By signing below I authorize the Child Development Center, the School Age Program or the Youth Center to automatically charge my account for any balance due for services that have not been paid by the close of business on the second day of each week.

_____ _____

Signature Date

This document contains personal data subject to the Privacy Act of 1974, 10 USC 8012 & EO 9397. Requires safeguarding and disclosure only as authorization in AFI 37-132. Confidentiality applies.

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: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ 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: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ 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 you 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

_____

_____

_____

_____

_____

_____

_____

_____

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 _____

PREPARTICIPATION PHYSICAL EVALUATION
THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	**No**
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	**No**
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

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 _____

PREPARTICIPATION PHYSICAL EVALUATION
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, 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 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 (questions 5–14).

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

Preparticipation Physical Evaluation
CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

  Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

EMERGENCY INFORMATION

Allergies _____

Other information _____

23 D MDG, MOODY AFB SPORTS PHYSICAL

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE	
DATE	***SECTION 1: PARENT OR PARTICIPANT TO COMPLETE***	
	1. Have you had a medical illness or injury since your last checkup or sports physical?	YES/NO
	2. Have you ever been hospitalized overnight?	YES/NO
	3. Have you ever had surgery?	YES/NO
	4. Are you currently taking any prescription or nonprescription (over the counter) medications?	YES/NO
	5. Have you ever used an inhaler?	YES/NO
	6. Have you ever passed out during exercise?	YES/NO
	7. Have you ever had chest pain during or after exercise?	YES/NO
	8. Do you get tired more quickly than your friends do during exercise?	YES/NO
	9. Have you ever had racing of your heart or skipped heartbeats?	YES/NO
	10. Have you ever had high blood pressure or high cholesterol?	YES/NO
	11. Have you ever been told you have a heart murmur?	YES/NO
	12. Has anyone in the family died of heart problems or sudden death before age 50?	YES/NO
	13. Has a physician ever denied or restricted your participation in sports for heart problems?	YES/NO
	14. Do you have any current skin problems (itching, rashes, acne, warts, fungus, or blisters)?	YES/NO
	15. Have you ever had a head injury or concussion?	YES/NO
	16. Have you ever had a seizure?	YES/NO
	17. Have you ever become ill from exercising in the heat?	YES/NO
	18. Do you cough, wheeze, or have trouble breathing during or after activity?	YES/NO
	19. Do you have asthma?	YES/NO
	20. Have you ever had problems with your eyes or vision?	YES/NO
	21. Have you broken or fractured any bones or dislocated any joints?	YES/NO
	22. Have you ever had any other problems with pain or swelling in muscles, tendons, bones, or joints?	YES/NO
	23. Have you had a medical illness or injury since your last checkup or sports physical?	YES/NO

ALLERGIES TO MEDICINES:
OTHER ALLERGIES:

EXPLANATION OF "YES" ANSWERS:

RECORDS MAINTAINED AT:		
PATIENT'S NAME ***(Last, First, Middle initial)***		**SEX**
RELATIONSHIP TO SPONSOR:	**STATUS**	**RANK/GRADE**
SPONSOR'S NAME		**ORGANIZATION**
DEPART/SERVICE	**SSN/IDENTIFICATION NO.**	**DATE OF BIRTH**

23 D MDG, MOODY AFB SPORTS PHYSICAL

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	CONTACT INFORMATION:
	In case of emergency, notify:
	1. Name *Phone: Home* *Work* *Cell*
	1. Name *Phone: Home* *Work* *Cell*
	Physician: **Physician's Phone**
	I hereby state that to the best of my knowledge, the above answers are complete
	Parent/ Athlete: Date:
	SECTION 2: TECHNICIAN AND PROVIDER COMPLETE
	Vitals: BP: Pulse: Resp: Weight: Height: (_____%ile)
	Medical: Appearance: Normal Abnormal
	Eyes, Ears, Nose, Throat Normal Abnormal
	Lymph Nodes Normal Abnormal
	Cardiovascular Normal Abnormal
	Lungs Normal Abnormal
	Genitalia (boys) Normal Abnormal
	Skin Normal Abnormal
	Musculoskeletal: Neck Normal Abnormal
	Spine Normal Abnormal
	Upper Extremities Normal Abnormal
	Lower extremities Normal Abnormal
	☐ Cleared to participate in all athletics
	☐ Cleared to participate in all athletics with the following exceptions:
	☐ Needs further evaluation:
	PROVIDER SIGNATURE AND STAMP DATE