Parent Form

Athlete's Emergency Information

Sport(s): _____ Birthdate: _____

Name: _____ Sex: M F Age: _____ Grade: _____

Address: _____ City: _____ Zip: _____

Parent's Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact (Other than parents) Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insurance: _____ Policy/Member #: _____

Circle any of the following that apply: Diabetes Seizures Asthma Heart Condition Allergies

Any medications currently being taken: _____

Any allergies to medications: _____

In case of a serious injury requiring immediate attention school district employees are authorized to give first aid and obtain treatment or emergency hospital care.

Signature of Parent or Guardian: _____ Date: _____

To be completed by the ***School Nurse*** **only**

I have received PHYSICIAN'S **CLEARANCE** AND PHYSICAL REPORT: _____
Nurse's signature

Notes: _____

_____

Sport: _____ Date of Physical: _____

PRE-PARTICIPATION PHYSICAL EVALUATION HISTORY

Date of Physical Exam_____

Name_____Sex_____Age_____Date of Birth_____

Grade_____ School_____Sport(s)_____

Address_____City/State_____Zip_____

Personal Physician_____Physician's Phone Number_____

Explain "YES" (Y) answers below. Circle questions to which you do not know the answers.

	Y	N		Y	N
1.Has a doctor ever denied or restricted your participation in sports for any reason?			26.Have you ever used or taken asthma medicine?		
2.Do you have a medical condition (like asthma or diabetes)?			27.Were you born without or are your missing a kidney, an eye, a testicle, or any other organ?		
3.Are you currently taking any prescription or nonprescription (over the counter) medicines or pills?			28.Have you had infectious mononucleosis (mono) within the last month?		
4.Do you have allergies to medicines, pollens, foods or stinging insects?			29.Do you have any rashes, pressure sores, or other skin problems.?		
5.Have you ever passed out or nearly passed out during exercise?			30.Have you had a herpes skin infection?		
6.Have you ever passed out or nearly passed out after exercise?			31.Have you ever had a head injury or concussion?		
7.Have you ever had discomfort, pain, or pressure in your chest during exercise?			32.Have you ever been hit in the head and been confused or lost your memory?		
8. Does your heart race or skip beats during exercise?			33.Have you ever had a seizure?		
9.Has a doctor ever told you that you have ___ high blood pressure?			34.Do you have headaches with exercise?		
10.Has a doctor ever ordered a test for your heart?			35.Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
11.Has anyone in your family died for no apparent reason?			36.Have you ever been unable to move your arms or legs after being hit or falling?		
12.Does anyone in your family have a heart problem?			37.When exercising in the heat, do you have severe muscle cramps or become ill?		
13.Has anyone family member or relative died of heart problems or of sudden death before the age of 50?			38.Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
14.Does anyone in your family have Marfan syndrome?			39.Have you had any problems with your eyes or visions.		
15.Have you ever spent the night in the hospital?			40.Do you wear glasses or contact lenses?		
16.Have you ever had surgery?			41.Do you wear protective eyewear such as goggles or a face shield?		
17.Have you ever had an injury like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game?			42. Are you happy with your weight?		
18.Have you had any broken or fractured bones or dislocated joints?			43.Are you trying to gain or lose weight?		
19.Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, cast, or crutches?			44.Has anyone recommended you change your weight or eating habits?		
20.Have you ever had a stress fracture?			45.Do you limit or carefully control what you eat?		
21.Have you been told that you have or have had an x-ray for atlantoaxial (neck) instability?			46.Do you have any concerns that you would like discuss with a doctor?		
22.Do you regularly use a brace or assistive device?			**FEMALES ONLY:**		
23.Has a doctor ever told you that you have asthma or allergies?			47.Have you ever had a menstrual period?		
24.Do you cough, wheeze, or have difficulty breathing?			48.How old were you when you had your first menstrual period?		
25.Is there anyone in your family who has asthma?			49.How many periods have you had in the last 12 months?		

Explain "Yes" (Y) 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/Spirit Group member_____Date_____

Signature of Parent/Guardian_____Date_____

PARTICIPATION PHYSICAL EXAMINATION FORM – PHYSICIAN'S FORM

This form must be completed (all areas), signed by a physician, stamped with agency/office stamp and returned to the School Nurse before athletic/spirit group clearance can be issued.

LAST NAME: _____ FIRST NAME: _____ Date of Birth: _____

Sports:_____ GRADE: _____

ALLERGIES: _____ MEDICATIONS: _____

CIRCLE ANY OF THE FOLLOWING THAT APPLY: DIABETES SEIZURES ASTHMA HEART CONDITION

DATE OF PHYSICAL EXAMINATION: _____ Height: _____ Weight: _____ Pulse: _____ BP: _____

Hearing: ☐ Passed Right/Left <25 dB's all frequencies Vision: R 20/___ L 20/___ Both 20/___ Corrected?: Y N
☐ Failed_____ ☐ Not Done

MEDICAL	NORMAL	ABNORMAL FINDINGS
General Appearance		
Eyes/ears/nose/throat		
Hearing		
Lymph nodes		
Heart		
Murmurs		
Pulses		
Lungs		
Abdomen		
Genitourinary (males only)+		
Skin		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back (including scoliosis screen)		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		

+Having a third party present is recommended for the genitourinary examination.

Assessment: _____

☐ Cleared for all sports without restrictions.
☐ Not cleared – Reason _____
☐ Deferred – Requires further evaluation – Reason: _____

Agency/Office stamp here

Name of physician (print) _____ Address: _____ Telephone:_____

Signature of Physician _____M.D. or D.O. Today's date: _____
(Must be a licensed medical doctor)

(revised 5/18)