PLEASE COMPLETE ALL FORMS!!

PREPARTICIPATION EVALUATION **EMERGENCY TREATMENT FORM**

To All Parents/Guardians:

Many hospitals and doctors will not treat a child without parent's consent (unless a matter of life or death). It is requested that you complete the information below so that if your child requires a visit to the hospital while under the supervision of the school, this will allow the hospital to treat the injury.

EMERGENCY INFORMATION

Name: _____ Sport(s): _____ 2012-2013 Grade: _____

Sex: M _____ F _____ Age: _____ Date of Birth: _____/_____/_____ Social Security Number: _____

Mother's Name: _____

Work Phone #: _____ Cell Phone #: _____

Father's Name: _____

Work Phone #: _____ Cell Phone #: _____

Home Address: _____

Home Phone #: _____ E-Mail: _____

Secondary Emergency Contact: _____

Relationship: _____ Phone #: _____

Insurance Name: _____ Insurance #: _____

Policy #: _____ Group #: _____

Primary Care Physician: _____ Phone #: _____

Allergies: _____

List Emergency Medical Conditions: (Asthma, Diabetes, Seizures, etc.) _____

_____

I. Consent Statement: Authorizing Treatment

I hereby give my consent for (student's name) _____ to be treated in the event of an emergency, injury or illness.

Name of Parent/Guardian: _____

Parent/Guardian Signature: _____

II. Consent Statement: Representing School

I hereby give my consent for (student's name) _____ to represent (school's name)

_____ in the sport of _____.

Name of Parent/Guardian: _____

Parent/Guardian Signature: _____

PLEASE COMPLETE ALL FORMS!!

PREPARTICIPATION EVALUATION — HISTORY FORM

NAME: _____ SPORT(S): _____

EXPLAIN "YES" ANSWERS BELOW. CIRCLE QUESTIONS YOU DON'T KNOW THE ANSWERS TO.

1. Has a doctor ever denied or restricted your participation in sports for any reason? ..... Y N

2. Do you have an ongoing medical condition (like diabetes or asthma)? ..... Y N

3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? ..... Y N

4. Do you have allergies to medicines, pollens, foods, or stinging insects? ..... Y N

5. Have you ever passed out or nearly passed out DURING exercise? ..... Y N

6. Have you ever passed out or nearly passed out AFTER exercise? ..... Y N

7. Have you ever had discomfort, pain, or pressure in your chest during exercise? ..... Y N

8. Does your heart race or skip beats during exercise? ..... Y N

9. Has a doctor ever told you that you have:
- High Blood Pressure ..... Y N
- High Cholesterol ..... Y N
- A heart murmur ..... Y N
- A heart infection ..... Y N

10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) ..... Y N

11. Has anyone in your family died for no apparent reason? ..... Y N

12. Does anyone in your family have a heart problem? ..... Y N

13. Has any family member or relative died of heart problems or of sudden death before age 50? ..... Y N

14. Does anyone in your family have Marfan Syndrome? ..... Y N

15. Have you ever spent the night in a hospital? ..... Y N

16. Have you ever had surgery? ..... Y N

17. Have you every had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? ..... Y N

If Yes, explain: _____

18. Have you had any broken or fractured bones or dislocated joints? ..... Y N

If Yes, explain: _____

19. Have you ever had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? ..... Y N

If Yes, explain: _____

20. Have you ever had a stress fracture? ..... Y N

21. Have you been told that you have or have had an x-ray for atlantoaxial (neck) instability? ..... Y N

22. Do you regularly use a brace or assistive device? ..... Y N

23. Has a doctor ever told you that you have asthma or allergies? ..... Y N

24. Do you cough, wheeze or have difficulty breathing during or after exercise? ..... Y N

25. Is there anyone in your family who has asthma? ..... Y N

26. Have you ever used an inhaler or taken asthma medicine? ..... Y N

27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? ..... Y N

28. Have you had infectious mononucleosis (mono) within the last month? ..... Y N

29. Do you have rashes, pressure sores, or other skin problems? ..... Y N

30. Have you ever had a herpes skin infection? ..... Y N

31. Have you ever had a head injury or concussion? ..... Y N

32. Have you been hit in the head and been confused or lost your memory? ..... Y N

33. Have you ever had a seizure? ..... Y N

34. Do you have headaches with exercise? ..... Y N

35. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling? ..... Y N

36. Have you ever been unable to move your arms or legs after being hit of falling? ..... Y N

37. When exercising in the heat, do you have severe muscle cramps or become ill? ..... Y N

38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? ..... Y N

39. Have you had any problems with your eyes or vision? ..... Y N

40. Do you wear glasses or contact lenses? ..... Y N

41. Do you wear protective eyewear, such as goggles or a face shield? ..... Y N

42. Are you happy with your weight? ..... Y N

43. Are you trying to gain or lose weight? ..... Y N

44. Has anyone recommended you change your weight or eating habits? ..... Y N

45. Do you limit or carefully control what you eat? ..... Y N

46. Do you have any concerns that you would like to discuss with a doctor? ..... Y N

FEMALES ONLY

47. Have you ever had a menstrual period? ..... Y N

48. How old were you when you had your first menstrual period? ___

49. 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.

Name of Parent/Guardian: _____ Parent/Guardian Signature: _____

Name of Student-Athlete: _____ Student-Athlete Signature: _____

Questions taken from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, & American Osteopathic Academy of Sports Medicine 2004 PPE Form.

Beech High School 2012-2013

PLEASE COMPLETE ALL FORMS!!

PREPARTICIPATION EVALUATION **PHYSICAL EXAMINATION FORM**

NAME: _____ SPORT(S): _____

HEIGHT: _____ WEIGHT: _____ PULSE: _____ BP: _____/_____ (_____/_____, _____/_____)

VISION: R 20/_____ L 20/_____ CORRECTED: Y N If Yes, Glasses ____ Contacts ____ PUPILS: EQUAL ____ UNEQUAL ____

IMMUNIZATIONS (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; pneumococcal; meningococcal; varicella)

Up to date _____ Not up to date _____ Specify _____

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

*Multiple-examiner set-up only. **Having a third party present is recommended for the genitourinary examination.

_____ Cleared without restriction

_____ Not cleared for _____ Reason: _____

Recommendations: _____

_____

Name of physician (print/type): _____ **Date:** _____

Signature of physician: _____, **MD or DO**

Questions taken from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, & American Osteopathic Academy of Sports Medicine 2004 PPE Form.

PLEASE COMPLETE ALL FORMS!!

PREPARTICIPATION EVALUATION **CONSENT FORM**

NAME: _____ SPORT(S): _____

PROTECTED HEALTH INFORMATION AUTHORIZATION FOR RELEASE OF INFORMATION

I/We hereby authorize any medical provider associated with **Beech High School** to use and/or disclose my child's clearance and health recommendations to the athletic director, coaches and medical personnel at **Beech High School** to inform them of their health status for the participation in athletic or activities. I/We understand my refusal to sign this authorization may affect my child's ability to participate in athletics. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by state or federal law.

Name of Parent/Guardian: _____ Date: _____

Parent/Guardian Signature: _____

LEGAL MEDICAL CONSENT

I/We hereby give consent for (student-athlete's name) _____ to represent **Beech High School** in the sport(s) of _____; realizing that such activity involves the potential for injury. I/We acknowledge that even the best coaching, use of the most advanced equipment, and strict observance of rules, injuries are still a possibility. On rare occasions these injuries can be severe and result in total disability, paralysis, or even death. I/We further grant permission to **Beech High School** its physicians and/or athletic trainers to render aid, treatment, medical or surgical care deemed reasonably necessary to the health and well being of the above individual. I/We hold harmless **Beech High School** its agents, servants, and employees from any liability for damage and injury to the above individual and hereby accept the full responsibility to any and all damages or injuries sustained as a result of participation in the sport(s) or extracurricular activities named above.

I/We understand the above statements and consent for my child to participate in athletics at **Beech High School**.

Name of Parent/Guardian: _____ Date: _____

Parent/Guardian Signature: _____

INSURANCE COVERAGE

I/We understand that medical bills related to athletic injury are the responsibility of the parent/guardian. Occasionally, student athletes are injured during practices or games and the school needs to ascertain that the parent/guardian has medical insurance in order to cover expenses if an injury occurs.

EVERY ATHLETE MUST HAVE INSURANCE TO PARTICIPATE.

_____ I/We have personal insurance on (student-athlete's name) _____.

Name of Parent/Guardian: _____ Date: _____

Parent/Guardian Signature: _____