



Consent for Emergency Treatment and Medical Information

This information is confidential and is intended for use by authorized school officials only

Student name: _____
(Last Name) (First Name) (Middle Initial)

Birthdate: ____/____/____ Gender: Female Male Grade: _____

Fall Sport _____ Winter Sport _____ Spring Sport _____

Father/Guardian

Mother/Guardian

Name: _____

Name: _____

Home Phone: _____

Home Phone: _____

Mobile Phone: _____

Mobile Phone: _____

Work Phone: _____

Work Phone: _____

Email _____

Email _____

Emergency Contact (if parent/guardian is not available)

Contact Name: _____ Contact Phone: _____

Relationship to Student _____ Alt Phone: _____

Student Health Information

Primary Care Physician: _____ Physician Phone: _____

Insurance Company: _____ Policy # _____

Please list any medical/health problems (asthma, diabetes, epilepsy, heart conditions, seizures, etc)

History of Concussion - (Please list dates) _____

Please list any known allergies (including medications, food, latex, stings, etc...)

Medications taken daily _____

Hospital (preference) _____

In consideration of my child's opportunity to participate in interscholastic activities, I hereby consent to emergency medical treatment, hospitalization or other necessary health care treatment, including first aid, diagnostic procedures and medical treatment, as may be necessary for the welfare of my child, by a physician, qualified nurse, certified athletic trainer, and/or hospital in the event of injury or illness during all periods of time in which the student is away from his/her legal residence as a member of an interscholastic activity team or group, and hereby waive on behalf of myself and my child any liability of the school district, any agents or employees, arising out of such medical treatment. I also give permission to the Certified Athletic Trainer to release athletic injury information about my student to the appropriate medical staff and necessary APS school personnel in compliance with HIPPA (Health Insurance Portability and Accountability Act) Regulations.

Parent/Guardian Signature _____

Date _____

*This information page is valid for 1 school-year. If any changes in the above information occur, a new page must be completed by the parent/guardian and returned to the athletic department as soon as possible.

Medical Pre-Participation Physical Evaluation

This Page for Physician Only (Parent or physician can retain for records)

HISTORY FORM

(Note: Front page is to be filled out by the student/athlete and parent prior to seeing the physician)

Athlete Name _____ Date of birth _____

Sex _____ Age _____

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	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
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: _____			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
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: _____			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?		
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)?			40. Have you ever become ill while exercising in the heat?		
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?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have sickle cell trait or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Have you had any problems with your eyes or vision?		
BONE AND JOINT QUESTIONS	Yes	No	44. Have you had any eye injuries?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			45. Do you wear glasses or contact lenses?		
18. Have you ever had any broken or fractured bones or dislocated joints?			46. Do you wear protective eyewear, such as goggles or a face shield?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			47. Do you worry about your weight?		
20. Have you ever had a stress fracture?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
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)			49. Are you on a special diet or do you avoid certain types of foods?		
22. Do you regularly use a brace, orthotics, or other assistive device?			50. Have you ever had an eating disorder?		
23. Do you have a bone, muscle, or joint injury that bothers you?			51. Do you have any concerns that you would like to discuss with a doctor?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			FEMALES ONLY		
25. Do you have any history of juvenile arthritis or connective tissue disease?			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?		

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

Parent/guardian completes page 1
(on the reverse side)
Give page 1 to Healthcare Provider

Healthcare Provider completes
and signs Page 3 →

Parent/guardian completes
and signs page 4
Submit pages 3 & 4 to the school

PHYSICAL EXAMINATION FORM

(This page is to be completed by the Physician or Certified Medical Provider. This page should then be turned into the school)

Date of Exam / /
Month Day Year
(Exam is good for one calendar year from this date)

Student/Athlete Name _____ Date of birth _____

Grade _____

EXAMINATION		
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP _____ / _____ (_____ / _____)	Pulse _____	Vision R20/ _____ L 20/ _____ Corrected <input type="checkbox"/> Y <input type="checkbox"/> 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* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) [†]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [‡]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

†Consider GU exam if in private setting. Having third party present is recommended.

‡Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

Describe any significant medical or health problems (asthma, diabetes, epilepsy, hearing condition, kidney problems, etc.) that could affect the student/athlete's participation

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 pre-participation 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 MD/DO, PA, NP, DC-SPC# (print/type) _____ Date _____

Address _____ Phone _____

Signature of MD/DO, PA, NP, DC-SPC# _____

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