#### ATHLETIC PHYSICAL RELEASE FORM

- 1. <u>PHYSICALS</u>- **On Tuesday, August 22nd St. Joseph High School will provide free physicals** for our athletes at the Family Activity Center (gym) on campus. ALL athletes (grades 7 through 12) who plan on participating in ANY sports during the 2017-2018 school year must have a physical. Students must report to the gym at the appropriate times. All students in grades 7-9 must be at the gym by 5:45 and all students in grades 10-12 must be at the gym by 6:15.
- 2. Please COMPLETE AND SIGN all of the Health Screening Form and the Emergency Action Information Sheet and have <u>STUDENTS BRING WITH THEM TO THE GYM</u> on the night of the physicals.
- 3. <u>INSURANCE</u>- Insurance is required for participation in school athletics. It is the responsibility of the parent to secure insurance for their child. Parents may also purchase insurance or additional insurance offered through the school. Please see Coach Bruich for these forms. **MAKE SURE YOU FILL OUT THE INSURANCE INFORMATION IN THIS PACKET!**

Our screening conducted by our physicians has been a good start for physical evaluation. We encourage you, however, to have a complete physical for your child by your family doctor if there is ever any evidence of need or especially for youngsters just starting a physical activity program.

By my signature, I agree to hold harmless of neglect any physician volunteering for St. Joseph School, any adult

chaperone, staff member, the school, or the paragraph athletics.	rish in case an accident occurs while my child is a participant in St.
Child's name	Parent/Guardian
Diane Wolfe, Principal	Brent Bruich, Athletic Director

## **EMERGENCY ACTION INFORMATION SHEET**

DATE			
STUDENT'S NAME		-	
PARENT NAME		-	
ADDRESS			
PHONE		_	
DATE OF BIRTH G	RADE	_	
PARENT EMAIL			
NAME OF HEALTH INSURANCE CO			
POLICY NO.			
NOTIFY IN CASE OF EMERGENCY			
EMERGENCY CONTACT #1:		PHONE	
EMERGENCY CONTACT #2:		PHONE	
PAST MEDICAL HISTORY (past or current cardiac, pulmonary, or orthope known allergies)			
CONSENT TO GIVE Over The Counter MEDIO I give my consent for the Athletic Staff of St. Jos to my child as needed and by the directions give release and hold harmless St. Joseph Schools and expense, demand, or action, etc. against them for	CATIONS (Ibupro seph Schools to ad n on the product la d any of their staff	fen, Tylenol, Pepto I minister over-the-co bel of the desired me members or agents f	unter medications edication. I agree to rom lawsuit, claim,
SignedSignature of parent or legal guardian		Date	
Signature of parent or legal guardian			

This form is CONFIDENTIAL and for EMERGENCIES!!!! It will be taken to away games and kept on file at home games for the safety of your child.

#### ■ PREPARTICIPATION PHYSICAL EVALUATION

# PHYSICAL EXAMINATION FORM

Name \_

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?  • Nave you ever their disparettes, 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?  • Nave you ever taken anabolic steroids or used any other performance supplier  • Have you ever taken any supplements to help you gain or lose weight or kingro  • Do you wear a seat belt, use a helmet, and use condoms?  2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).		ce?		
Height Weight	☐ Male 〔	] Female		
BP / ( / ) Pulse	Vision R 2	D/	L 20/	Corrected D Y D N
MEDICAL		NORMAL	T	ABNORMAL FINDINGS
Appearance	Transaction		1	
<ul> <li>Marfan stigmata (kyphosoeliosis, high-arched palate, pectus excavatum, arache arm span &gt; height, hyperlaxity, myopla, MVP, aortic insufficiency)</li> <li>Eyes/ears/noso/throat</li> <li>Pupils equal</li> <li>Hearing</li> </ul>	ocactyly,			
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) <sup>a</sup>				
Skin  HSV, lesions suggestive of MRSA, tinea corporis				
Neurologic <sup>4</sup>			1	
MUSCULOSKELETAL				
Neck.			1	
Back			1	
Shoulder/arm				
Elbow/forearm			18	
Wrist/hand/fingers				
Hip/thigh				
Knee			-	
Leg/ankle Foat/toes			+	
Functional	_		+	
Duck-walk, single leg hop				
-Consider EOD, echocardiogram, and referral to cardiology for abserted cardiochistery or examConsider Gill some if its private setting. Pashing this party present is concernmentedConsider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concus		for		
☐ Not cleared				
□ Pending further evaluation				
☐ For any sports				
☐ For certain sports	sames nav-	more entre	11175-51175	
Reason				
Recommendations				
I have examined the above-named student and completed the preparticipation participate in the sport(s) as outlined above. A copy of the physical exam is on tions arise after the athlete has been cleared for participation, the physician mexplained to the athlete (and parents/guardians).	record in my offi	ce and can be ma	de available to th	e school at the request of the parents. If condi- ed and the potential consequences are completely
Name of physician (print/type)				
Address				Phone
Signature of physician				, MD or 0
© 2010 American Academy of Family Physicians, American Academy of Pediatrics, A Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine wasso				

Date of birth \_\_\_\_

## ■ PREPARTICIPATION PHYSICAL EVALUATION

## HISTORY FORM

Note: 7	his form is to be filled out b	w the patient and	parent prior to seeing	the physician. The	physician should keep this form in	the chart.)
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Name					Date of birth		
Sex	Age	Grade 5	School		Sport(s)		
Medicine	s and Allergies: P	lease list all of the prescription and o	ver-the-co	unter m	edicines and supplements (herbal and nutritional) that you are currently	y taking	
Do you ha	ve any allergies?	☐ Yes ☐ No If yes, please i	dentify sp	ecific all	lergy below.		
xplain "Yes	s" answers below.	Circle questions you don't know the	answers t	lo.	26		
GENERAL O			Yes	No	MEDICAL QUESTIONS	Yes	No
1. Has a di any reas		restricted your participation in sports for			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you l	have any ongoing me	edical conditions? If so, please identify semia   Diabetes  Infections			27. Have you ever used an inhaler or taken asthma medicine?  28. Is there anyone in your family who has asthma?		
	u ever spent the nigh	t in the hospital?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
	u ever had surgery?			-	30. Do you have groin pain or a painful bulge or hemia in the groin area?		
	LTH QUESTIONS AB	BOUT YOU	Yes	No	31. Have you had infectious mononucleosis (mono) within the last month?		
5. Have yo	u ever passed out or	nearly passed out DURING or			32. Do you have any rashes, pressure sores, or other skin problems?		
	exercise?				33. Have you had a herpes or MRSA skin infection?		
	u ever had discomfor uring exercise?	rt, pain, tightness, or pressure in your			34. Have you ever had a head injury or concussion?		
		skip beats (irregular beats) during exercis	e?	· ·	35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
	octor ever told you th ill that apply:	at you have any heart problems? If so,			36. Do you have a history of seizure disorder?	1	
	h blood pressure	☐ A heart murmur			37. Do you have headaches with exercise?		
☐ Hig	h cholesterol	☐ A heart infection			38. Have you ever had numbness, tingling, or weakness in your arms or		
	vasaki disease	THE RESIDENCE OF THE PARTY OF T			legs after being hit or falling?  39. Have you ever been unable to move your arms or legs after being hit	+-	$\vdash$
	octor ever ordered a t idiogram)	test for your heart? (For example, ECG/EKG	1		or falling?	$\perp$	
10. Do you	get lightheaded or fee	el more short of breath than expected			40. Have you ever become ill while exercising in the heat?	-	-
	exercise? su ever had an unexpl	Coursian bender	+		41. Do you get frequent muscle cramps when exercising?	+	-
the same of the sa		rt of breath more quickly than your friends			Do you or someone in your family have sickle cell trait or disease?      Have you had any problems with your eyes or vision?	+	-
	exercise?	n or present more query and your menda	27		44. Have you had any eye injuries?	_	1
HEART HEA	LTH QUESTIONS AB	OUT YOUR FAMILY	Yes	No	45. Do you wear glasses or contact lenses?	_	
		stative died of heart problems or had an			46. Do you wear protective eyewear, such as goggles or a face shield?	+	+
drownin	cted or unexplained s to, unexplained car as	udden death before age 50 (including ocident, or sudden infant death syndrome)	,		47. Do you worry about your weight?	1	
14. Does an	ryone in your family h	nave hypertrophic cardiomyopathy, Marfan ight ventricular cardiomyopathy, long 0T	_		48. Are you trying to or has anyone recommended that you gain or lose weight?		
syndron	ne, short QT syndrom	e, Brugada syndrome, or catecholaminerg	ic		49. Are you on a special diet or do you avoid certain types of foods?	1	-
	phic ventricular tach				50. Have you ever had an eating disorder?	+	1
	ryone in your family h ed defibrillator?	nave a heart problem, pacemaker, or			51. Do you have any concerns that you would like to discuss with a doctor?		
		d unexplained fainting, unexplained	_		FEMALES ONLY		
	s, or near drowning?				52. Have you ever had a menstrual period?		
BONE AND	JOINT QUESTIONS	4	Yes	No	53. How old were you when you had your first menstrual period?		
		to a bone, muscle, ligament, or tendon		1	54. How many periods have you had in the last 12 months?		
	ised you to miss a pro	actice or a game? en or fractured bones or dislocated joints?	-		Explain "yes" answers here		
		that required x-rays, MRI, CT scan,	18				
	ns, therapy, a brace, a						
	u ever had a stress fr						
21. Have yo instabili	u ever been told that ty or atlantoaxial inst	you have or have you had an x-ray for nex ability? (Down syndrome or dwarfism)	k				
22. Do you	regularly use a brace	, orthotics, or other assistive device?					
		or joint injury that bothers you?	18				
ASSESSMENT OF THE PARTY.	Contract to the Contract of th	painful, swollen, feel warm, or look red?	-15				
25. Do you	have any history of ju	venile arthritis or connective tissue diseas	e?				
l hereby st	ate that, to the be	est of my knowledge, my answers	to the abo	ve que	stions are complete and correct.		
Signature of at	Note	Signatu	ne of parentily	uardian _	Date		
©2010 Amer	rican Academy of Fan	nily Physicians, American Academy of Ped	iatrics, Ame	rican Coll	lege of Sports Medicine, American Medical Society for Sports Medicine, American	Orthopae	edic



### Arkansas Activities Association Concussion Fact Sheet for Athletes and Parents

#### WHAT IS A CONCUSSION

Athlete's Signature

Parent / Guardian Signature

A concussion is an injury that changes how the cells in the brain normally work. A concussion is caused by a blow to the head or body that causes the brain to move rapidly inside the skull. Even a "ding", "getting your bell rung," or what seems to be mild bump or blow to the head can be serious. Concussions can also result from a fall or from players colliding with each other or with obstacles, such as a goalpost.

#### WHAT ARE THE SIGNS AND SYMPTOMS OF A CONCUSSION Observed by the Athlete Observed by the Parent / Guardian, Headache or "pressure" in head Coach, or Teammate Nausea or vomiting Is confused about assignment or position Balance problems or dizziness Forgets an instruction Double or blurry vision Is unsure of game, score, or opponent Bothered by light Moves clumsily Bothered by noise Answers questions slowly Feeling sluggish, hazy, foggy, or groggy Loses consciousness (even briefly) Difficulty paying attention Shows behavior or personality changes Can't recall events after hit or fall Memory Problems Confusion Appears dazed or stunned Does not "feel right" WHAT TO DO IF SIGNS/SYMPTOMS OF A CONCUSSION ARE PRESENT Parent / Guardian Athlete TELL YOUR COACH IMMEDIATELY Seek medical attention Inform parents Keep your child out of play Seek medical attention Discuss play to return to play with coach Give your self time to recover Address academic needs WHERE CAN I FIND OUT MORE INFORMATION? Center for Disease Control www.cdc.gov/concussion/HeadUp/youth.html NFHS Free Concussion Course http://nfhslearn.com/electiveDetail.aspx?courseID=15000 RETURN TO PLAY GUIDELINES Remove immediately from activity when signs/symptoms are present. Release from medical professional required for return (Neuropsychologist, MD. DO, Nurse Practitioner, Certified Athletic Trainer, or Physician Assistant) 3. Follow school district's return to play guidelines and protocol SIGNATURES By signing below, I acknowledge that I have received and reviewed the attached AAA Concussion in Sports Fact Sheet for Athletes and Parents. I also acknowledge and I understand the risks of brain injuries associated with participation in school athletic activity.

Print Name

Print Name

Date

Date