

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 _____ Date of birth _____

Name _____

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: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> 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, lightheadedness, 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: <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 <input type="checkbox"/> 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	Yes	No
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 _____

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I hereby give permission for the release of the attached student medical history and the results of the actual physical examination to the school for the purposes of participation in athletics and activities.
Parent or Legal Guardian Signature _____ 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

- 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?
- Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION		
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP _____ / _____ (/)	Pulse _____	Vision R 20/ _____ 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, linea 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.

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

Please Fill out Both Sides
and Return¹⁵⁶ to the School

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 _____

To be completed for
students participating in
all NSAA activities.



NEBRASKA SCHOOL ACTIVITIES ASSOCIATION (NSAA)
Student and Parent Consent Form

School Year: 20____-20____ Member School: _____
Name of Student: _____
Date of Birth: _____ Place of Birth: _____

The undersigned(s) are the Student and the parent(s), guardian(s), or person(s) in charge of the above named Student and are collectively referred to as "Parent".

The Parent and Student hereby:

- (1) Understand and agree that participation in NSAA sponsored activities is voluntary on the part of the Student and is a privilege;
- (2) Understand and agree that (a) by this Consent Form the NSAA has provided to the Parent and Student of the existence of potential dangers associated with athletic participation; (b) participation in any athletic activity may involve injury of some type; (c) the severity of such injury can range from minor cuts, bruises, sprains, and muscle strains to more serious injuries to the body's bones, joints, ligaments, tendons, or muscles, to catastrophic injuries to the head, neck and spinal cord, and on rare occasions, injuries so severe as to result in total disability, paralysis and death; and, (d) even the best coaching, the use of the best protective equipment and strict observance of rules, injuries are still a possibility;
- (3) Consent and agree to participation of the Student in NSAA activities subject to all NSAA by-laws and rules interpretations for participation in NSAA sponsored activities, and the activities rules of the NSAA member school for which the Student is participating; and,
- (4) Consent and agree to (a) the disclosure by the Member School at which the Student is enrolled to the NSAA, and subsequent disclosure by the NSAA, of information regarding the Student, including the student's name, address, telephone listing, electronic mail address, photograph, date of and place of birth, major fields of study, dates of attendance, grade level, enrollment status (e.g., full-time or part-time), participation in officially recognized activities and sports, weight and height of as a member of athletic teams, degrees, honors and awards received, statistics regarding performance, records or documentation related to eligibility for NSAA sponsored activities, medical records, and any other information related to the Student's participation in NSAA sponsored activities; and, (b) the Student being photographed, video recorded, audio taped, or recorded by any other means while participating in NSAA activities and contests, consent to and waive any privacy rights with regard to the display of such recordings, and waive any claims of ownership or other rights with regard to such photographs or recordings or to the broadcast, sale or display of such photographs or recordings.

I acknowledge that I have read paragraphs (1) through (4) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities.

DATED this _____ day of _____, _____.

Name of Student [Print Name]

Student Signature

(I am)(We are) the Student's [circle appropriate choice] (Parent) (Guardian). (I)(We) acknowledge that (I)(We) have read paragraphs (1) through (4) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities. Having read the warning in paragraph (3) above and understanding the potential risk of injury to my Student, (I)(we) hereby give (my)(our) permission for _____ [insert student name] to practice and compete for the above named high school in activities approved by the NSAA, except those crossed out below:

Baseball	Golf	Tennis	Play Production	Basketball	Swimming/Diving
Track	Football	Speech	Cross Country	Soccer	Volleyball
Music	Football	Softball	Wrestling	Debate	Journalism

DATED this _____ day of _____, _____.

Parent [Print Name]
Revised April 2012

Parent Signature

STUDENT NAME _____ GRADE _____

EMERGENCY MEDICAL (RELEASE) INFORMATION SIGN-OFF SHEET

1. I/we have read the policies concerning activities found in the Activities Handbook and understand them fully. I/we agree that my/our son/daughter will abide by these policies while he/she is involved in activities of Cozad Middle School and/or High School and that the school and its sponsors/coaches will follow these policies.
2. I/we further understand that should there ever be a time whereby I/we have a question regarding these policies or if my/our son/daughter has not been in accordance with these policies, a conference may be requested with school personnel - Principal, Activities Director and/or Coach/Sponsor - to discuss the matter further. Complete due process procedure for NSAA policies are available from the Activities Director.
3. I/we understand the school carries NO insurance of any kind to cover medical expenses incurred while participating, and I/we will assume all such expenses personally.
(Please examine your insurance policies carefully to make sure they cover interscholastic athletic participation and if they do not, the school has information on special insurance policies for athletic participation.)
4. I/we hereby give my/our consent for our son/daughter to accompany any school group of which he/she is a member on any of its local or out of town trips. I/we authorize the school to obtain, through a physician of it's own choice, any emergency medical care that may become reasonably necessary for the student in the course of such activities or such travel.



Parent/guardian Signature _____ Date _____

MEDICAL INFORMATION SIGN-OFF SHEET
Please complete the following Emergency Information

Parent's Address _____

Home Phone# _____

Mother's Work Phone # _____ Father's Work Phone# _____

If no answer, call in case of emergency (include name and phone #) _____

Physician's Name _____ Home Phone # _____ Work Phone # _____

Hospitalization Insurance (Type, Group and ID#) _____

History of Diabetes YES NO History of Epilepsy YES NO

Please List Any Allergies to Sulfa, Penicillin, etc... _____

Parent/Guardian gives permission to administer anesthetic and/or emergency treatment as required:
YES NO



Parent/Guardian Signature _____ Date _____

My child's medical history from school records may be shared with supervising coaches & staff members

Consent to Perform Urinalysis for Drug Testing (APPENDIX B)

We hereby consent to allow the student named on the front of this form to undergo urinalysis testing for the presence of illicit drugs or banned substances in accordance with the **Policy and Procedure for Random Urine Drug Testing of Cozad Community Schools Students** as approved by the Cozad Community Schools Students Board of Education. We understand that the collection process will be overseen by a qualified vendor. We understand that any urine samples will be sent only to a certified medical laboratory for actual testing, and that the samples will be coded to provide confidentiality.

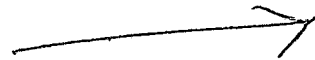
We hereby give our consent to the medical vendor selected by the Cozad Community Schools Board, their laboratory, doctors, employees, or agents, together with any clinic, hospital, or laboratory designated by the selected medical vendor to perform urinalysis testing for the detection of illicit drugs or banned substances.

We further give permission to the medical vendor selected by the Cozad Community Schools Board, its doctors, employees, or agents, to release all results of these tests to the Medical Review Officer (MRO) working for the medical vendor. We understand these results will be forwarded to the Building Principal and will also be made available to us.

We understand that consent pursuant to this Informed Consent Agreement will be effective for all activities in which this student might participate during the current school year.

We hereby release the Cozad Community Schools Board of Education, SPORT SAFE Testing Service, Inc. and its employees from any legal responsibility or liability for the release of such information and records.

READ CODE OF CONDUCT AND EXPECTATIONS ON REVERSE SIDE AND SIGN!



**COZAD COMMUNITY SCHOOLS
CODE OF CONDUCT AND EXPECTATIONS
INFORMED CONSENT AGREEMENT (APPENDIX B)**

Student Name (Print) _____ Grade _____

Parent/Guardian/Custodian Name (print) _____

Home Phone _____

Work Phone _____

AS A STUDENT:

I understand and agree that participation in athletics and parking on school grounds is a privilege that may be withdrawn for violations of the Code of Conduct and Expectations, hereinafter Code of Conduct. I have read the Code of Conduct and thoroughly understand the consequences that I will face if I do not honor my commitment to the Code of Conduct. I understand and realize that there is risk of injury in participating in activities. I understand that when I participate in any athletic program, and/ or receive a parking permit, I will be subjected to initial and random urine drug testing, and if I refuse, I will not be allowed to practice, participate or park. I have read the consent on the reverse of this form and agree to its terms. I understand this is binding while a student within the Cozad Community Schools.

Student Signature _____ Date _____

AS A PARENT/GUARDIAN/CUSTODIAN:

I have read the Code of Conduct and understand the responsibilities of my son/daughter/ward as a participant in athletic, and/or parking privileges in the Cozad Community Schools Students. I understand and realize that there is an assumed risk of injury involved for my son/daughter/ward as a participant in activities. I understand that my son/daughter/ward, when participating in athletics, and/or receiving a parking permit, may be subjected to initial and random urine drug testing, and if they refuse, will not be allowed to practice, participate, or park. I have read the consent on the reverse of this form and agree to its terms. I also understand that if my son/daughter/ward has completed their season and does not intend on participating in other activities and/or parking for the remainder of the year, I may remove them from the random program with a signed consent to Designated Official. Failure to do so is my consent to offer the deterrence of random drug testing for my son/daughter/ward until the end of the testing year. I understand this is binding while my son/daughter/ward is a student within the Cozad Community Schools.

Parent/Guardian/Custodian Signature _____ Date _____