HIGH SCHOOL ATHLETIC PARTICIPATION SCREENING FORM

Name: _____ Grade: _____ M/F
(PRINT LEGIBLY) Last First Middle or Nickname **(In Fall)** **Circle**

Birthdate: _____ ID#: _____ Sport: _____Fall _____Winter _____Spring

HEALTH HISTORY TO BE COMPLETED BY PARENT OR GUARDIAN

Has your child: **↓ If you answer "YES" to any questions, please explain below↓**

1. Had a medical illness or injury that has disqualified him/her from athletic participation? YES
2. Ever been hospitalized or undergone any surgical operations(s)? YES
3. Had an ongoing chronic or serious illness (such as diabetes, kidney problems, seizures or asthma)? YES
4. Ever taken any supplements or vitamins to help gain/lose weight or improve athletic performance? YES
5. Ever passed out during/after exercise or become ill from exercising? YES
6. Ever tired earlier than expected during exercise or complained of extreme fatigue? YES
7. Ever had chest pain or unusual/irregular heartbeats during or after exercise? YES
8. Had any history of heart problems, heart murmur, high blood pressure or high cholesterol? YES
9. Had any family member or relative die before the age of 50 or die of heart-related problems? YES
10. Had any family history of specific heart issues? If "YES," check all that apply: YES
    ☐Hypertrophic Cardiomyopathy ☐Arrhythmia ☐Marfan's Syndrome ☐Long QT Syndrome
11. Had any history of concussion, head injury, loss of memory or being unconscious? YES
12. Had any history of seizures, convulsions or fainting episodes? YES
13. Had frequent or severe headaches? YES
14. Ever had a "stinger," "burner," or pinched nerve (numbness or tingling down an extremity)? YES
15. Had any problems with vision that require glasses, contacts, or protective eyewear? YES
16. Had special protective or corrective equipment/devices that are not usually used for sports? YES
    Examples: knee brace, neck roll, foot orthotics, retainer for teeth, hearing aids?
17. Been diagnosed with a contagious skin condition within the past month? YES
18. Ever broken/fractured any bones or dislocated any joints? YES
19. Had any recurring problems with pain or swelling in back, muscles, tendons, bones or joints? YES
20. Is your child currently under the care of a physician for any medical, orthopedic or emotional concerns? YES
21. Had any history of asthma, allergies to foods, medicines, or stinging insects? YES
    If "YES," what medications are used? Is Epi-Pen needed? _____
22. Does your child require any special health procedure(s) during the regular school day or during athletics? YES
23. Is your child currently taking any prescription or "over-the-counter" medications or using an inhaler or Epi-Pen? YES
    If "YES," list all medications:
    Medication: _____ Dose: _____ Frequency: _____
    Medication: _____ Dose: _____ Frequency: _____
    Medication: _____ Dose: _____ Frequency: _____

↓If you have answered "YES" to any of the above questions, please explain below↓

_____

_____

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

Date: _____ **Signature of Parent/Guardian:** _____

Signature of Student: _____

PHYSICAL SCREENING TO BE COMPLETED BY HEALTHCARE PROVIDER

THIS IS NOT A COMPLETE PHYSICAL EXAMINATION

	Normal		Normal
General:		Musculoskeletal:	
Eyes, ears, nose, throat		Neck and shoulders	
Neck		Spine	
Cardiovascular		Arms/hands	
Femoral pulses		Hips/thighs	
Chest and lungs		Knees	
Abdomen		Ankles/feet	
Skin			

Visual acuity (Distance): Right: / Left: /
☐Corrected ☐Uncorrected
Height:
Weight:
Blood pressure:
Pulse:
DATE OF EXAM:

Recommendation: ☐Full activity-No restrictions ☐Activity with restrictions ☐No contact sports ☐No participation ☐Other

Comments: _____

_____

Examining Healthcare Provider: _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

Healthcare Provider Office Stamp

HIGH SCHOOL ATHLETIC CONSENT FORM

Name: _____ _____ I.D.# _____ ___/___/___ GR._____ M/F
Last First Birth Date (In Fall) Circle

Parent /Guardian Name: _____ _____ Hm. Phone: ( ) _____
Last First Wk. Phone: ( ) _____
Cell Phone: ( ) _____

Address: _____

EMERGENCY CONTACT IN THE EVENT PARENT/GUARDIAN CANNOT BE REACHED:

Name: _____ _____ Hm. Phone: ( ) _____
Last First Wk. Phone: ( ) _____
Relationship: ☐ Parent ☐ Guardian ☐ Step Parent ☐ Relative ☐ Friend Cell Phone: ( ) _____

Name: _____ _____ Hm. Phone: ( ) _____
Last First Wk. Phone: ( ) _____
Relationship: ☐ Parent ☐ Guardian ☐ Step Parent ☐ Relative ☐ Friend Cell Phone: ( ) _____

PLEASE READ EACH STATEMENT AND SIGN AT THE BOTTOM

I. CONSENT FOR EMERGENCY TREATMENT

Treatment Consent: In the event of an accident or emergency, I (we) give permission for the school authorities to take my (our) child to any doctor or hospital, or request their services. If not, please advise the school as to what action you would like to be taken:

_____

Athletic Trainer Consent: I give my permission to the Athletic Trainer to administer first aid, follow-up treatment and rehabilitation when appropriate in his/her professional judgment, as approved by the consulting physician.

YES OR NO

II. MEDICATION DURING ATHLETICS

My child may need medication during school hours, athletic practices, field trips, or competitions. This may include prescription medication, such as inhalers or EpiPen OR over-the-counter medication such as Advil or Tylenol. I understand that my child's physician and I, as the parent/guardian, need to complete an IUSD Parent/Guardian and Physician Request for Medication form which can be obtained from the school Health Office or www.iusd.org

YES OR NO

III. PHYSICIANS CONSENT

I authorize permission for my child to receive an Athletic Participation Physical Screening. I understand that this does not replace a complete physical examination done by our own physician. (If your child has ANY medical condition that may exclude his/her participation in athletics, please see your own physician and return the physician report to the school.)

YES OR NO

IV. INSURANCE CERTIFICATION

I hereby certify that my child is insured for accidental death insurance in the amount of $1,500 and for at least $1,500 insurance protection for medical and hospital expenses resulting from accidental bodily injury while participating in inter-school athletic events or while being transported to and from such athletic events.

YES OR NO

Please check one of the following:

____ My child is insured for the above activity under our family Health/Medical Plan.
Name of Company _____ PPO – HMO – KAISER – OTHER (circle one)
____ I have purchased the school insurance plan.

V. TRANSFER ELIGIBILITY

Has student attended ANY other High School? If yes, name of school _____

YES OR NO

VI. COMMUNICATION PROCEDURES

I understand that the orderly use of the following procedures is suggested when offering input to the Athletic Department, and that written documentation is recommended.

1. **Discuss needs, complaints or concerns with the Coach.**
2. **If not satisfied, request a conference with the Athletic Director.**
3. **If individual conferences with Coach and Athletic Director are not satisfying, then a conference with all parties will be held with the Assistant Principal of Athletics.**
4. **If the athlete and/or parent(s) are still not satisfied, then an appeal may be made to the Principal.**
5. **I have read and understand the Athletic Code.**

VII. PARENT OR GUARDIAN CONSENT

I hereby give my consent for the above named student to compete in IUSD approved activity programs such as: Sports, Marching Band, Cheerleading Squad, etc. and travel with the school representative on necessary school trips. I realize that there is a risk of serious injury or death from participating in school sports and related activities. It is understood that the school district, the student body, and/or any of the employees are not financially responsible in case of accident or injury.

Date:	**Signature of Parent/Guardian:**