



For school year 20____ - 20____

Athletic Participation/Parental Consent/Physical Examination Form

To be completed and signed by parent/guardian.

Separate signed form is required for each school year - May 1 of the current year through June 30 of the succeeding year.

ATHLETIC PARTICIPATION

Student's Name _____ DOB ____ / ____ / ____

Address _____ Grade ____ Age ____

City/St/Zip _____ Male Female

ACKNOWLEDGEMENT OF RISK AND INSURANCE STATEMENT

I give permission for _____ (student name) to participate in any of the following sports that are not crossed out: baseball, basketball, cross country, golf, soccer, tennis, track, volleyball.

I am aware that with the participation in sports comes the risk of injury to my child. I understand that the degree of danger and the seriousness of the risk varies significantly from one sport to another with contact sports carrying the higher risk. I have had an opportunity to understand the risk inherent in sports through meetings, written handouts, or some other means. He/she is insured by our family policy with:

Name of Medical Insurance Company: _____

Policy #: _____ Policy Holder: _____

I am aware that participating in sports will involve travel with the team. I acknowledge and accept the risks inherent in the sport and with the travel involved and with this knowledge in mind, grant permission for my child to participate in the sport and travel with them.

By this signature, I hereby consent to allow the physician(s) and other health care provider(s) selected by myself or the school to perform a pre-participation examination on my child and to provide treatment for any injury or condition resulting from participating in athletics/activities for his/her school during the school year covered by this form. I further consent to allow said physician(s) or health care providers(s) to share appropriate information concerning my child that is relevant to participation in athletics and activities with coaches and other school personnel as deemed necessary.

EMERGENCY PERMISSION FORM

Please list any significant health problems that might be significant to a physician evaluating your child **in case of emergency**:

Please list any allergies to medications, etc.: _____

Is the student currently prescribed an inhaler or Epi-Pen? Yes No List the emergency medication: _____

Is the student presently taking any other medication? Yes No If yes, what type: _____

Does the student wear contact lenses? Yes No Date of last Tdap or Td (tetanus) shot: ____/____/____

EMERGENCY AUTHORIZATION: In the event I cannot be reached in an emergency, I hereby give permission to physicians selected by The New Community School coaches and staff to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the person named above.

Daytime phone number to reach you in an emergency: (____) _____ Cell phone: (____) _____

Evening phone number to reach you in an emergency: (____) _____

Parent/Guardian signature: _____ Date: ____/____/____

*Emergency Permission Form may be reproduced to travel with respective teams and is acceptable for emergency treatment if needed. The pre-participation physical examination is not a substitute for a thorough annual examination by a student's primary care physician.



MEDICAL HISTORY

This form must be completed and signed prior to the physical examination for review by examining practitioner. Explain "Yes" answers below with number of the question. Circle questions you don't know the answers to.

GENERAL MEDICAL HISTORY		YES	NO	MEDICAL QUESTIONS (continued)		YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>		27. Do you have asthma or use asthma medicine (inhaler, nebulizer)?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Do you currently have an ongoing medical condition? If so, please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>		28. Were you born without or are you missing a kidney, an eye, a testicle, spleen, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Have you ever spent the night in the hospital?	<input type="checkbox"/>	<input type="checkbox"/>		29. Do you have groin pain or a painful bulge or hernia in the groin area?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>		30. Have you had mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	
HEART HEALTH QUESTIONS ABOUT YOU		YES	NO	31. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>		32. Have you ever had a herpes or MRSA skin infection?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>		33. Are you currently taking any medication on daily basis?	<input type="checkbox"/>	<input type="checkbox"/>	*
7. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>		34. Have you ever had a head injury or concussion? If so, date of last injury: ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	
8. Has a doctor ever told you that you have: <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:	<input type="checkbox"/>	<input type="checkbox"/>		35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Has a doctor ever ordered a test for your heart? (ex: ECG/EKG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>		36. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>	
10. Do you get lightheaded or feel more short of breath than expected during exercise?	<input type="checkbox"/>	<input type="checkbox"/>		37. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>	
11. Have you ever had an unexplained seizure?	<input type="checkbox"/>	<input type="checkbox"/>		38. When exercising in heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>	
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		YES	NO	39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Has any family member or relative died of heart problems or had an unexpected sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?	<input type="checkbox"/>	<input type="checkbox"/>		40. Have you had any other blood disorders?	<input type="checkbox"/>	<input type="checkbox"/>	
13. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>		41. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	
14. Does anyone in your family have a pacemaker or implanted defibrillator?	<input type="checkbox"/>	<input type="checkbox"/>		42. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	
15. Does anyone in your family have Marfan syndrome, cardiomyopathy, or Long Q-T?	<input type="checkbox"/>	<input type="checkbox"/>		43. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>	
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	<input type="checkbox"/>	<input type="checkbox"/>		44. Do you worry about your weight?	<input type="checkbox"/>	<input type="checkbox"/>	
BONE AND JOINT QUESTIONS		YES	NO	45. Are you trying to or has any professional recommended that you try to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>	
17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis that caused you to miss a practice or game?	<input type="checkbox"/>	<input type="checkbox"/>		46. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>	
18. Have you had any broken or fractured bones or dislocated joints?	<input type="checkbox"/>	<input type="checkbox"/>		47. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?	<input type="checkbox"/>	<input type="checkbox"/>		48. What is the date of your last Tdap or Td (tetanus) immunization? (circle type) ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	
20. Have you ever had an x-ray of your neck for atlanto-axial instability?	<input type="checkbox"/>	<input type="checkbox"/>		49. Do you have an allergy to medicine, food, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	
21. Have you ever had a stress fracture of a bone?	<input type="checkbox"/>	<input type="checkbox"/>		FEMALES ONLY:			
22. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>		50. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>	
23. Do you currently have a bone, muscle, or joint injury that bothers you?	<input type="checkbox"/>	<input type="checkbox"/>		51. Age when you had your first menstrual period? ____			
24. Do any of your joints become painful, swollen, feel warm, or look red?	<input type="checkbox"/>	<input type="checkbox"/>		52. How many periods have you had in the last 12 months? ____			
25. Do you have a history of juvenile arthritis or connective tissue disease?	<input type="checkbox"/>	<input type="checkbox"/>		EXPLAIN "YES" ANSWERS BELOW:			
MEDICAL QUESTIONS		YES	NO	# ____ : _____			
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>		# ____ : _____			
				# ____ : _____			
				# ____ : _____			
				# ____ : _____			
				*List medications and nutritional supplements you are currently taking here:			
				<div style="border: 1px solid black; height: 40px;"></div>			

Parent/Guardian Signature: _____ Date: ____/____/____ Athlete Signature: _____



PHYSICAL EXAMINATION

Physical Exam form is required each school year dated after May 1 of the preceding school year and is good through June 30 of the current school year.

Student's Name _____ DOB ____ / ____ / ____

Height _____ Weight _____ Male Female

BP ____/____ Resting Pulse _____ Vision R 20/____ L 20/____ Corrected Yes No

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

Medical Practitioner to School Staff (please indicate any instructions or recommendations here)

Emergency medications required on-site Inhaler Epinephrine Glucagon Other: _____

Comments:

I have reviewed the data above, reviewed his/her medical history form, and make the following recommendations for his/her participation in athletics.

- CLEARED WITHOUT RESTRICTIONS**
- CLEARED WITH FOLLOWING NOTATION:** _____
- Cleared **AFTER** documented further evaluation or treatment for: _____
- CLEARED FOR LIMITED PARTICIPATION** (check and explain reason for all that apply): "Limited Until Date" when appropriate.
 - Not cleared for (specific sports) _____ Until Date: ____/____/____
 - Reason(s): _____
- NOT CLEARED FOR PARTICIPATION** Reason(s): _____

By this signature, I attest that I have examined the above student and completed this pre-participation physical including a review of Page 2 - Medical History.

Physician Signature: _____ *MD, DO, LNP, PA (circle one) Date: ____/____/____

Examiner's Name and Degree (print): _____ Phone #: (____) _____

Address: _____ City _____ St _____ Zip _____

***Only signatures of Doctor of Medicine, Doctor of Osteopathic Medicine, Nurse Practitioner, or Physician's Assistant licensed to practice in the United States will be accepted.**



CONCUSSION FACT SHEET AND ACKNOWLEDGEMENT FORM

To be signed by student athlete and parent/guardian

A concussion is a brain injury and is defined as a complex pathophysiological process affecting the brain, induced by biomechanical forces. Several common features that incorporate clinical, pathologic and biomechanical injury constructs that may be utilized in defining the nature of a concussive head injury include:

- Concussion may be caused either by a direct blow to the head, face, neck, or elsewhere on the body with an “impulsive” force transmitted to the head.
- Concussion typically results in the rapid onset of short-lived impairment of neurologic function that resolves spontaneously. However, in some cases, symptoms and signs may evolve over a number of minutes to hours.
- Concussion may result in neuropathological changes, but the acute clinical symptoms largely reflect a functional disturbance rather than a structural injury and, as such, no abnormality is seen on standard structural neuroimaging studies.
- Concussion results in a graded set of clinical symptoms that may or may not involve loss of consciousness. Resolution of the clinical and cognitive symptoms typically follows a sequential course, however it is important to note that in some cases symptoms may be prolonged.

No two concussions are the same, even for a single athlete. As a result, at the time of injury, it is impossible to predict the duration and severity of symptoms that the athlete will experience. Research has shown that the majority (80-90%) of concussions resolve in a 7-10 day period, although the recovery time frame may be longer in children and adolescents.

Symptoms of a concussion may include one or more of the following:

- | | | | |
|----------------------|---------------------------|----------------------------|--------------------------|
| • Headache | • Balance Problems | • Difficulty Concentrating | • Irritable |
| • “Pressure in Head” | • Sensitivity to Light | • Difficulty Remembering | • Sadness |
| • Neck Pain | • Sensitivity to Noise | • Fatigue or Low Energy | • Nervousness/Anxiety |
| • Nausea/Vomiting | • Feeling Slowed Down | • Confusion | • Trouble Falling Asleep |
| • Dizziness | • Feeling like “in a fog” | • Drowsiness | |
| • Blurred Vision | • “Don’t Feel Right” | • More Emotional | |

Signs observed by teammates, parents, and coaches include:

- | | | |
|---|--|--|
| • Appears Dazed | • Moves Clumsily or is Uncoordinated | • Seizures or Convulsions |
| • Vacant Facial Expression | • Answers Questions Slowly | • Any Change in Typical Behavior/
Personality |
| • Confusion About Assignment | • Shows Behavior or Personality Change | • Slurred Speech |
| • Forgets Plays | • Can’t Recall Events Prior to Hit | • Loses Consciousness |
| • Is Unsure of Game, Score, or Opponent | • Can’t Recall Events After Hit | |

TNCS strongly recommends that all participants and parents/guardians view the NFHS online video, “Concussion in Sports, What You Need to Know” to learn about the signs, symptoms, and treatment of concussions. The video takes approximately 15 minutes and is free to view at NFHSLearn.com.

I, _____ (athlete’s name) have been educated on the signs and symptoms of a concussion; I understand the risks of continuing to participate in my sport with a concussion, including but not limited to second impact syndrome, permanent brain damage or death; and I accept the responsibility of reporting concussive signs and/or symptoms for myself and my teammates to New Community staff.

Athlete Name (print) _____ Athlete Signature _____

Parent Name (print) _____ Parent Signature _____

Date ____/____/____