For school year 20 19 - 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 _____ Rising Grade _____ Age _____

City/St/Zip _____ ☐ Male ☐ Female

Student Cell phone: (_____) _____

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 concering 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 physcial 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
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you currently have an ongoing medical condition? If so, please identifiy: ☐Asthma ☐Anemia ☐Diabetes ☐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, or pressure in your chest during exercise?	☐	☐
7. Does your heart race or skip beats during exercise?	☐	☐
8. Has a doctor ever told you that you have: ☐High blood pressure ☐A heart murmur ☐High cholesterol ☐A heart infection ☐Kawasaki disease ☐Other:	☐	☐
9. Has a doctor ever ordered a test for your heart? (ex: 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?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**
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 suddent infant death syndrome)?	☐	☐
13. Does anyone in your family have a heart problem?	☐	☐
14. Does anyone in your family have a pacemaker or implanted defibrillator?	☐	☐
15. Does anyone in your family have Marfan syndrome, cardiomyopathy, or Long Q-T?	☐	☐
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, like a sprain, muscle, or ligament tear, or tendonitis that caused you to miss a practice or game?	☐	☐
18. Have you had any broken or fractured bones or dislocated joints?	☐	☐
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?	☐	☐
20. Have you ever had an x-ray of your neck for atlanto-axial instability	☐	☐
21. Have you ever had a stress fracture of a bone?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐
23. Do you currently 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 a 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?	☐	☐

MEDICAL QUESTIONS (continued)	YES	NO
27. Do you have asthma or use asthma medicine (inhaler, nebulizer)	☐	☐
28. Were you born without or are you missing a kidney, an eye, a testicle, spleen, or any other organ?	☐	☐
29. Do you have groin pain or a painful bulge or hernia in the groin area?	☐	☐
30. Have you had mononucleosis (mono) within the last month?	☐	☐
31. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
32. Have you ever had a herpes or MRSA skin infection?	☐	☐
33. Are you currently taking any medication on daily basis?	☐*	☐
34. Have you ever had a head injury or concussion? If so, date of last injury: ____/____/____	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36. Do you have headaches with exercise?	☐	☐
37. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
38. When exercising in heat, do you have severe muscle cramps or become ill?	☐	☐
39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
40. Have you had any other blood disorders?	☐	☐
41. Have you had any problems with your eyes or vision?	☐	☐
42. Do you wear glasses or contact lenses?	☐	☐
43. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
44. Do you worry about your weight?	☐	☐
45. Are you trying to or has any professional recemmended that you try to gain or lose weight?	☐	☐
46. Do you limit or carefully control what you eat?	☐	☐
47. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
48. What is the date of your last Tdap or Td (tetanus) immunization? (circle type) ____/____/____	☐	☐
49. Do you have an allergy to medicine, food, or stinging insects	☐	☐
FEMALES ONLY: 50. Have you ever had a menstrual period?	☐	☐
51. Age when you had your first menstrual period? ____		
52. How many periods have you had in the last 12 months? ____		

EXPLAIN "YES" ANSWERS BELOW:

#____ : _____

#____ : _____

#____ : _____

#____ : _____

#____ : _____

*List medications and nutritional supplements you are currently taking here:

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 instructins 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 type of brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head. Concussions can also occur from a blow to the body that causes the head and brain to move rapidly back and forth. Even what seems to be a mild bump to the head can be serious. 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 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
- "Pressure in Head"
- Neck Pain
- Nausea/Vomiting
- Dizziness
- Blurred Vision
- Balance Problems
- Sensitivity to Light
- Sensitivity to Noise
- Feeling Slowed Down
- Feeling like "in a fog"
- "Don't Feel Right"
- Difficulty Concentrating
- Difficulty Remembering
- Fatigue or Low Energy
- Confusion
- Drowsiness
- More Emotional
- Irritable
- Sadness
- Nervousness/Anxiety
- Trouble Falling Asleep

Signs observed by teammates, parents, and coaches include:

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

For additional information regarding concussion in sports, TNCS strongly recommends that participants and parents/guardians visit the CDC's Heads Up website at: www.cdc.gov/headsup/youthsports/parents and/or the National Federation of State High School Associations (NFHS) website at: www.nfhslearn.com/courses/61129/concussion-in-sports.

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 ____/____/____