optim sports medicine
PATIENT FOCUSED • PHYSICIAN OWNED

# ***PARENT/GUARDIAN CONSENT & RELEASE FORM***

To provide the best possible medical care for your child, a medical record will be established for him/her. If your child should become injured while playing sports, this form will provide important information to coaches and medical personnel. Please complete and sign as indicated.

**Student's Name (Legal)**_____,_____,_____
LAST FIRST MI

Student's Preferred Name _____ D.O.B._____/_____/_____ HS Graduation Year: 20_____

Address: _____, GA _____
Street City Zip

Student's Home Phone #:_____ Student's Cell Phone #: _____

**Father/Guardian's Name:** _____ Employer: _____

Father/Guardian's Cell Phone #: _____ Work Phone # _____

**Mother/Guardian's Name:** _____ Employer: _____

Mother/Guardian's Cell Phone #: _____ Work Phone # _____

Parent/Guardian Contact E-Mail Address: _____

**Emergency Contact (must be 21 or older):** _____Relationship:_____

Contact Home Phone #: _____ Contact Cell Phone # _____

## INSURANCE INFORMATION

**Primary Insurance Co:** _____ **Name of Policy Holder:**_____

Policy #: _____ Group #: _____

**Primary Physician:** _____ Office Phone # (_____)_____-_____ext _____

## *****PLEASE BE AWARE OF THE FOLLOWING WHEN CARING FOR MY CHILD*****

Medical Conditions: _____

Allergies: _____

Medications & Condition: _____

## PERMISSION FOR AUTHORIZATION TO TREAT IN PARENT'S ABSENCE

*I give permission for school representatives to authorize medical treatment for my child in my absence. This may include, but is not limited to, activation of emergency services, emergency room procedures, and injury/illness evaluation treatment by certified athletic trainers at away competitions.

**Print Parent Name:**_____ **Parent Signature:**_____

**Date:** _____/_____/_____

## ATHLETIC TRAINING & COMPETITION PARTICIPATION: Parental Consent and Insurance Information.

I am the legal guardian of the above named student. By signing this statement, I am granting permission for my child to participate in the athletic program at Bulloch Academy School from the June 1, 2022 through May 31, 2023. This acknowledgement of risk and consent to allow participation shall remain in effect until revoked in writing. I understand and acknowledge the following:

1. **School Function:** I understand that while involved in sports related school programs, my child is to obey the rules and regulations of Bulloch Academy.

2. **Assumption of Risk**: Although participation in supervised interscholastic athletics and school activities may be one of the least hazardous in which students will engage in or out of school, **BY ITS NATURE, PARTICIPATION IN INTERSCHOLASTIC ATHLETICS AND SCHOOL ACTIVITIES INCLUDES RISK OF INJURY, WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG-TERM CATASTROPHIC INJURY, INCLUDING PERMANENT PARALYSIS FROM THE NECK DOWN OR DEATH.** Although serious injuries are not common in supervised school athletic programs or the school setting, it is possible only to minimize, not eliminate, risk. Students can and do have responsibility to help reduce the potential for injury. **STUDENTS AND PLAYERS MUST OBEY ALL SAFETY RULES, REPORT ALL PHYSICAL PROBLEMS TO THEIR TEACHERS/COACHES, FOLLOW A PROPER CONDITIONING PROGRAM, AND INSPECT THEIR EQUIPMENT DAILY.** By signing this consent form, you acknowledge that you have read and understand this warning. **PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THE RISKS DESCRIBED IN THIS WARNING SHOULD NOT SIGN THE FORM.**

3. **Bulloch Academy Athletic Physicals Policy:** All students must have a current, up to date physical on file with the front office in order to participate in athletics. The physical must be valid within the previous 12 months. No student may participate in athletics with a physical dated earlier than 12 months before the date of participation. If your child is not cleared for sport participation during physicals, your child must have a complete evaluation by your family physician with the proper paperwork signed and on file with the school for clearance. Verify that the information on this form is correct and understand that any false information may result in my son/daughter being declared ineligible to participate. I further acknowledge and consent to the Internet storage and delivery of this information by Bulloch Academy and Optim Sports Medicine and its affiliated vendors to medical providers, as appropriate.

4. **Bulloch Academy Insurance Policy:** Bulloch Academy has a student accident policy which is included in tuition. This is a supplemental policy which pays 80% of the balance not paid by your family policy a $100 policy deductible. If your child is not covered under your policy please inform the front office. I also acknowledge as a guardian, I am responsible for all payments of medical coverage for an injury. I also agree not to hold the school or any of its employees, representatives, or other agents acting on its behalf liable for any costs related to medical treatment, care or transportation as a result of any injury my child may incur while participating in Bulloch Academy's athletic teams.

5. **Consent to Treat:** I hereby grant parental consent to Optim Sports Medicine for assessment/treatment of any injuries my child may suffer during the school year during athletic training or competition. I give permission for school officials, chaperones, or representatives of Optim Sports Medicine overseeing the athletic training or competition in which my child is participating to seek medical aid and render first aid if such attention is necessary, at the sole discretion of such individual. In case of emergency and when I cannot be immediately reached by telephone or otherwise, I give permission to the physician selected by school officials to hospitalize, secure proper treatment, and order injections, anesthesia, or surgery for my child. I agree to be responsible for all medical expenses incurred in connection therewith. In the event the school incurs expenses for medical treatment, I agree to reimburse school in full.

6. **Travel:** I understand and agree that my child shall be permitted to ride in an approved Bulloch Academy bus and/or vehicle while he/she is involved in the activity.

7. **Medical Information:** I, being of lawful age, hereby authorize and consent to having Optim Sports Medicine Program Athletic Trainers and/or their consulting physician(s) provide any requested medical information to other physicians, healthcare providers, high school coaches or school administration, intercollegiate teams, professional teams, scouts, recruiters, or athletic trainers that directly pertains to my participation at Bulloch Academy. Said authorization to release medical information will include, but is not limited to, information concerning illnesses, injuries, treatments, hospitalizations, examinations, X-rays, or other forms of diagnostic testing occurring while participating in activities at said school or athletic organization. I understand that I may revoke this authorization by providing written notice to Optim Sports Medicine. I also understand that I am authorizing access to the student's medical records and patient identifiable information by executed this release. This authorization shall be valid for one (1) year commencing on the effective date executed below. I understand that the release of my medical information is being carried out with my consent and so assume full responsibility.

**THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTOOD THE ABOVE.**

| | |
|---|---|
| _____ | _____ |
| **Parent/Guardian Signature** | **Date** |
| _____ | _____ |
| **Print Name** | **Relationship to Student** |

***Please complete/sign/date every line (if applicable) in order for your student athlete to be eligible to participate.***

# GEORGIA INDEPENDENT ATHLETIC ASSOCIATION

# STUDENT / PARENT CONCUSSION AWARENESS FORM

**DANGERS OF CONCUSSION**

Concussions at all levels of sports have received a great deal of attention and a State Law has been passed to address this issue. Adolescent athletes are particularly vulnerable to the effects of concussion. Once considered little more than a minor "ding" to the head it is now understood that a concussion has the potential to result in death, or changes in brain function (either short-term or long term). A concussion is a brain injury that results in a temporary disruption of normal brain function. A concussion occurs when the brain is violently rocked back and forth or twisted inside the skull as a result of a blow to the head or body. Continued participation in any sport following a concussion can lead to worsening concussion symptoms, as well as increased risk for further injury to the brain, and even death.

Player and parental education in this area is crucial – that is the reason for this document. Refer to it regularly. This form must be signed by a parent or guardian of each student who wishes to participate in GIAA Athletics. One copy needs to be returned to the school, and one retained at home.

**COMMON SIGNS AND SYMPTOMS OF CONCUSSION**

- Headache, dizziness, poor balance, moves clumsily, reduced energy level / tiredness.
- Nausea or vomiting.
- Blurred vision, sensitivity to light and sounds.
- Fogginess of memory, difficulty concentrating, slowed thought processes, confused about surroundings or game assignments.
- Unexplained changes in behavior and personality.
- Loss of consciousness (NOTE: This does not occur in all concussion episodes.)

**GIAA Concussion Policy**: If a Coach observes a Student-Athlete exhibit any sign, symptom, or behavior consistent with a concussion or head injury, the Coach must immediately remove that Student-Athlete from practice, conditioning, or game. The Student-Athlete may not return to practice, conditioning, or game until a Health Care Provider has determined that the Student-Athlete has not suffered a concussion. In the case where a Health Care Provider has determined that the Student-Athlete has suffered a concussion, the Student-Athlete may not resume practice, conditioning, or participation in games until medically determined capable of doing so for full or graduated return. In no circumstance may a Student-Athlete return to practice, conditioning, or a game on the same day that a concussion has been diagnosed by a Health Care Provider or cannot be ruled out

***By signing this Concussion Awareness Form, we give permission to the school to transfer this Form to all sports that this child may play. We are aware of the dangers of concussions and this signed Form will represent myself and this child during the current school year _____. This form will be stored with the Athlete's Physical Form and any other accompanying forms required by the Georgia Independent Athletic Association (GIAA).***

**WE HAVE READ THIS FORM AND UNDERSTAND THE FACTS REPRESENTED IN IT.**

SCHOOL NAME:_____

STUDENT'S NAME:_____ STUDENT'S SIGNATURE:_____
(PRINTED)

PARENT'S NAME:_____ PARENT'S SIGNATURE:_____
(PRINTED)

DATE SIGNED:_____

# GEORGIA INDEPENDENT ATHLETIC ASSOCIATION

# HEAT POLICY AWARENESS FORM

**Definitions:**

A. **"Practice"** means the period of time that a student engages in coach-supervised, school-approved preparation for sport whether indoors or outdoors, including Acclimation Activities, conditioning, weight training, distance running, and scrimmages, but not including a Walk Through.

B. **"Walk Through"** means the period of time, not exceeding one hour per day, that a student engages in coach-supervised, school-approved sessions, whether indoors or outdoors, to work on formations, schemes, and techniques without physical contact. No protective equipment is worn during a Walk Through. No conditioning activities are held during a Walk Through. A Walk Through may not be held on a day when two practices are being held.

C. **"Acclimation Activities"** in football means practicing in shorts, shoulder pads, and helmets for five consecutive weekdays prior to practicing in full pads. No contact will be allowed during this period. Starting Date for Acclimation is July 25.

D. **"WBGT"** stands for the Wet Bulb Globe Temperature reading, which is a composite temperature used to estimate the effect of air temperature, humidity, and solar radiation on the human body, expressed in degrees. It is not equated with the "Heat Index."

**Policy:** All Member Schools will utilize at each Practice a scientifically approved instrument that measures WBGT. At the following WBGT readings the corresponding activity, hydration, and rest break guidelines apply:

**Under 82.0**
**Normal activities.** Provide at least three separate rest breaks each hour of a minimum duration of 3 minutes each during Practice.

**82.0 - 86.9**
**Use discretion for intense or prolonged exercise.** Watch at-risk students carefully. Provide at least three separate rest breaks each hour of a minimum of four-minute duration each during Practice.

**87.0 - 89.9**
**Maximum outdoor Practice time is two hours.** For football, students are restricted to helmets, shoulder pads, and shorts during Practice. All protective equipment must be removed for conditioning activities. For all sports, provide at least four separate rest breaks each hour of a minimum of four minutes each during Practice.

**90.0 - 92.0**
**Maximum outdoor Practice time is one hour.** No protective equipment may be worn during outdoor Practice and there may be no outdoor conditioning activities. There must be twenty minutes of rest breaks provided during the hour of outdoor Practice.

**Over 92**
**No outdoor activities or exercise.** Delay outdoor Practice until a lower WBGT reading occurs.

The following guidelines apply to **hydration and rest breaks**:

- Rest time should involve both unlimited hydrations (water or electrolyte drinks) and rest without any activity involved.
- For football, helmets should be removed during rest time.
- The site of the rest time should be a cooling zone not in direct sunlight, such as indoors, under a tent, or under a shade tree.
- When the WBGT is over 86, ice towels and spray bottles filled with ice water should be available in the cooling zone and cold immersion tubs will be available for a student showing signs of heat illness. A cold immersion tub may be anything, including a shower or wading pool that can be adapted to immerse a student in cold water and ice which is available within two-minutes travel from an outdoor Practice facility.

The following guidelines apply to **Practice**:

- All Member Schools must hold Acclimation Activities.
- No two-a-day Practices may exceed four hours for both sessions; no single Practice during two-a-days may exceed two hours. A three-hour rest period must be observed between the two sessions.
- No single Practice may last more than three hours.

Restrictions based on outdoor WBGT readings do not apply to indoor Practice where indoor air temperature is 85 degrees or less.

**Penalties**
Member Schools violating this policy will be fined a minimum of $500 and a maximum of $1,000 for the first offense. A Member School may be removed from membership for repeat violations.

***By signing this Heat Policy Form, we give permission to the school to transfer this Form to all sports that this child may play. We are aware of the dangers of heat and this signed Form will represent myself and this child during the current school year _____. This form will be stored with the Athlete's Physical Form and any other accompanying forms required by the Georgia Independent Athletic Association (GIAA).***

SCHOOL:_____

ATHLETIC DIRECTOR'S SIGNATURE:_____DATE:_____

STUDENT ATHLETE'S SIGNATURE:_____DATE:_____

PARENT'S SIGNATURE:_____DATE:_____

**GEORGIA INDEPENDENT ATHLETIC ASSOCIATION**

**STUDENT / PARENT SUDDEN CARDIAC ARREST AWARENESS FORM**

## LEARN THE EARLY WARNING SIGNS

If you or your child has had one or more of these signs, see your primary care physician:

- Fainting suddenly and without warning, especially during exercise or in response to loud sounds like doorbells, alarm clocks, or ringing phones.
- Unusual chest pain or shortness of breath during exercise.
- Family members who had sudden, unexplained and unexpected death before age 50.
- Family members who have been diagnosed with a condition that can cause sudden cardiac death, such as hypertrophic cardiomyopathy (HCM) or Long QT syndrome.
- A seizure suddenly and without warning, especially during exercise or in response to loud sounds like doorbells, alarm clocks, or ringing phones.

## LEARN TO RECOGNIZE SUDDEN CARDIAC ARREST

If you see someone collapse, assume they have experienced sudden cardiac arrest and respond quickly. This victim will be unresponsive, gasping or not breathing normally, and may have some jerking (seizure-like activity). Call for help and start CPR. You cannot hurt them.

## LEARN HANDS-ON CPR

Effective CPR saves lives by circulating blood to the brain and other vital organs until rescue teams arrive. It is one of the most important life skills you can learn – and it is easier than ever.

- Call 911 (or ask bystanders to call 911 and get an AED).
- Push hard and fast in the center of the chest. Kneel at the victim's side, place your hands on the lower half of the breastbone, one on top of the other, elbows straight and locked. Push down 2 inches, then up 2 inches, at a rate of 100 times/minute, to the beat of the song "Stayin' Alive."
- If an Automated External Defibrillator (AED) is available, open it and follow the voice prompts. It will lead you step-by-step through the process, and will never shock a victim that does not need a shock.

***By signing this Sudden Cardiac Arrest Form, we give permission to the school to transfer this Form to all sports that this child may play. We are aware of the dangers of sudden cardiac arrest and this signed Sudden Cardiac Arrest Form will represent myself and this child during the current school year _____. This form will be stored with the Athlete's Physical Form and any other accompanying forms required by the Georgia Independent Athletic Association (GIAA).***

**WE HAVE READ THIS FORM AND UNDERSTAND THE FACTS REPRESENTED IN IT.**

SCHOOL NAME:_____

STUDENT'S NAME:_____ (PRINTED) STUDENT'S SIGNATURE:_____

PARENT'S NAME:_____ (PRINTED) PARENT'S SIGNATURE:_____

DATE SIGNED:_____

## PREPARTICIPATION PHYSICAL EVALUATION

# HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

*Over the last 2 weeks, how often have you been bothered by any of the following problems? (**check box next to appropriate number**)*

| | Not at all | Several days | Over half the days | Nearly every day |
|---|---|---|---|---|
| Feeling nervous, anxious, or on edge | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Not being able to stop or control worrying | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Little interest or pleasure in doing things | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Feeling down, depressed, or hopeless | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

| GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.) | Yes | No |
|---|---|---|
| 1. Do you have any concerns that you would like to discuss with your provider? | ☐ | ☐ |
| 2. Has a provider ever denied or restricted your participation in sports for any reason? | ☐ | ☐ |
| 3. Do you have any ongoing medical issues or recent illness? | ☐ | ☐ |
| **HEART HEALTH QUESTIONS ABOUT YOU** | **Yes** | **No** |
| 4. Have you ever passed out or nearly passed out during or after exercise? | ☐ | ☐ |
| 5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | ☐ | ☐ |
| 6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? | ☐ | ☐ |
| 7. Has a doctor ever told you that you have any heart problems? | ☐ | ☐ |
| 8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. | ☐ | ☐ |

| HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*) | Yes | No |
|---|---|---|
| 9. Do you get light-headed or feel shorter of breath than your friends during exercise? | ☐ | ☐ |
| 10. Have you ever had a seizure? | ☐ | ☐ |
| **HEART HEALTH QUESTIONS ABOUT YOUR FAMILY** | **Yes** | **No** |
| 11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)? | ☐ | ☐ |
| 12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? | ☐ | ☐ |
| 13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? | ☐ | ☐ |

| BONE AND JOINT QUESTIONS | Yes | No |
|---|---|---|
| 14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game? | ☐ | ☐ |
| 15. Do you have a bone, muscle, ligament, or joint injury that bothers you? | ☐ | ☐ |
| **MEDICAL QUESTIONS** | **Yes** | **No** |
| 16. Do you cough, wheeze, or have difficulty breathing during or after exercise? | ☐ | ☐ |
| 17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? | ☐ | ☐ |
| 18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area? | ☐ | ☐ |
| 19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)? | ☐ | ☐ |
| 20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? | ☐ | ☐ |
| 21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? | ☐ | ☐ |
| 22. Have you ever become ill while exercising in the heat? | ☐ | ☐ |
| 23. Do you or does someone in your family have sickle cell trait or disease? | ☐ | ☐ |
| 24. Have you ever had or do you have any problems with your eyes or vision? | ☐ | ☐ |

| MEDICAL QUESTIONS (*CONTINUED*) | Yes | No |
|---|---|---|
| 25. Do you worry about your weight? | ☐ | ☐ |
| 26. Are you trying to or has anyone recommended that you gain or lose weight? | ☐ | ☐ |
| 27. Are you on a special diet or do you avoid certain types of foods or food groups? | ☐ | ☐ |
| 28. Have you ever had an eating disorder? | ☐ | ☐ |
| **FEMALES ONLY** | **Yes** | **No** |
| 29. Have you ever had a menstrual period? | ☐ | ☐ |
| 30. How old were you when you had your first menstrual period? | | |
| 31. When was your most recent menstrual period? | | |
| 32. How many periods have you had in the past 12 months? | | |

**Explain "Yes" answers here.**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.**

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

## PREPARTICIPATION PHYSICAL EVALUATION

# PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

### *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?
   - Have you ever tried cigarettes, e-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-enhancing 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?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

| EXAMINATION | | |
|---|---|---|
| Height: Weight: | | |
| BP: / ( / ) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N | | |
| **MEDICAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Appearance<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) | ☐ | |
| Eyes, ears, nose, and throat<br>• Pupils equal<br>• Hearing | ☐ | |
| Lymph nodes | ☐ | |
| Heart[a]<br>• Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) | ☐ | |
| Lungs | ☐ | |
| Abdomen | ☐ | |
| Skin<br>• Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis | ☐ | |
| Neurological | ☐ | |
| **MUSCULOSKELETAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Neck | ☐ | |
| Back | ☐ | |
| Shoulder and arm | ☐ | |
| Elbow and forearm | ☐ | |
| Wrist, hand, and fingers | ☐ | |
| Hip and thigh | ☐ | |
| Knee | ☐ | |
| Leg and ankle | ☐ | |
| Foot and toes | ☐ | |
| Functional<br>• Double-leg squat test, single-leg squat test, and box drop or step drop test | ☐ | |

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

## ■ PREPARTICIPATION PHYSICAL EVALUATION

# MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

### SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____